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HEALTH MAINTENANCE ORGANIZATION AMENDMENTS OF 1985

JANUARY 22 (legislative day, JANUARY 21), 1986.—Ordered to be printed

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Mr. HATCH, from the Committee on Labor and Human Resources, submitted the following

REPORT

together with

ADDITIONAL VIEWS

[To accompany S. 1762 and H.R. 2417]

The Committee on Labor and Human Resources, to which was referred the bills (S. 1762 and H.R. 2417) to amend the provisions of the Public Health Service Act relating to health maintenance organizations, having considered the same, reports favorably thereon with an amendment and recommends that the bill as amended do pass.

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I. Summary

As reported from Committee, S. 1762 amends title XIII of the Public Health Service Act and reauthorizes the Department of Health and Human Services' contingency loan fund designed to cover defaults under federal obligations arising from the HMO program.

The bill eliminates or phases out various Federal programs supporting the development of HMOs. The grants and contracts program for HMO feasibility surveys is eliminated, as is the program of grants, contracts and loan guarantees for planning and initial development costs. None of these authorities had been funded in recent years. The bill also repeals the never-used loan authority for the acquisition and construction of HMO ambulatory care facilities. The bill phases out the loan program for initial operating costs by limiting the program to HMOs which had received Federal development support in fiscal years 1981, 1982, 1983, 1984, and 1985.

The bill repeals or amends certain reporting and review requirements. The requirement for review by a health systems agency of Federal support of HMO activities is repealed. The bill also repeals the requirement that an HMO periodically demonstrate to the Secretary of the Department of Health and Human Services that it continues to meet the Federal requirements for HMOs. Under the provisions of law, HMOs continue to be subject to monitoring for compliance with Federal requirements. The requirements relating to the digest of State HMO laws is amended to require updating of the digest annually instead of quarterly. The bill repeals the requirement that the Secretary report annually to Congress on implementation of the financial disclosure requirements but maintains the Department's monitoring of that implementation.

The bill repeals the restriction that only title XIII funds may be used for HMO development.

The bill limits the authority of the Secretary to borrow from the Treasury to meet obligations of the loan fund to instances in which borrowing is necessary to meet guarantees issued before October 1, 1986. The existence of this loan fund is reauthorized through 1989.

S. 1762 further provides federally qualified HMO's with a thirty month exclusion from covering, under "basic health benefits," organ transplant procedures becoming "medically accepted" during that period. It also provides for a study of important aspects of the operation of title XIII and their effect on the health care marketplace, subscribers, employers and HMO's themselves.

Finally, it adds psychologists to the list of health professionals, such as dentists, optometrists, and podiatrists, set forth in the statute.

II. Background and Need for Legislation

The term "health maintenance organization" or prepaid health plan generally describes an entity which provides specific health services to its members for a prepaid, fixed payment. In one respect, this arrangement is like a traditional health insurance program in the fee-for-service system. A monthly premium payment insures some portion of the costs of health services that a subscriber may incur during period of time. However, an HMO is different

from the fee-for-service system and traditional health insurance program in several respects.

First, it is different in its approach to payment to providers of health care services. In an HMO, the fixed per capita payment places the provider at risk. Is is not reimbursed for each of the services provided, as are physicians or hospitals in the fee-for-service system. Since the HMOs providers' income is fixed it has an incentive to limit over utilization through health promotion, vigorous review of services, and other cost containment strategies.

Second, HMOs can be distinguished from a traditional health insurance program in the fee-for-service system in that they provide directly or through others, those comprehensive services specified in the HMO subscriber contract. A member of a Blue Cross/Blue Shield plan or other private health insurance plan in a fee-for-service arrangement does not have services provided by the plan. Rather, the member secures his own provider or providers whom the insurer then reimburses.

These characteristics of HMOs give them both the capacity and financial incentive to control the utilization of health services, to reduce the need of their members for health services through prevention and early intervention strategies, and to reduce the unit costs of the services they provide. While HMOs are not universally successful in reducing the overall health care costs of their members, on balance they are demonstrating significant savings. The per enrollee health care costs of some HMOs are as much as 40 percent less than the costs under traditional insurance programs, savings predominantly due to lower hospital utilization rates. Furthermore, HMOs have been shown to deliver good quality care, and to naturally encourage greater use of preventive health services.

Over the past ten years the HMO industry has expanded both in terms of the number of organizations in operation and the number of people enrolled in these plans. According to a recent study (National HMO Census—1984, Interstudy, Excelsior, Minnesota), the number of prepaid health plans (including both federally qualified and non-qualified plans) has increased over the past 11 years by over 450 percent, from 72 plans in 1973 to 337 plans by the end of 1984. The aggregate enrollment of these plans has grown by over 375 percent, from 4.4 million members in 1973 to 16.7 million by the end of 1984. During 1984, the number of prepaid plans grew by 16.2 percent while total membership increased by over 22 percent.

Since the passage of the Health Maintenance Organization Act of 1973, title XIII of the Public Health Service Act, the Federal Government has actively supported the growth of the HMO industry as an alternative to traditional insurance and health services delivery systems. This support has taken several forms, including: (1) grant and loan programs supporting the establishment of new HMOs, (2) Federal certification of HMOs meeting minimum organizational, benefit and financial standards, (3) preemption of State laws restricting HMO development, (4) requiring employers in the service area of a federally qualified HMO to offer one or more such HMOs as an option in the employers' health benefit programs, and (5) support of training and technical assistance programs assure that HMOs have access to the management and administrative skills needed to achieve their objectives.

In the past few years, as the HMO industry has matured and gained access to existing financial markets, Federal monetary support has been phased out.

Table 1 summarizes Federal financial support of HMO development activities since 1975. The Federal program supporting feasibility, planning and initial development grants awarded 904 grants and grant supplements, totaling $145 million, from 1975 through 1981. In 1980, the year with the largest total grant dollars, 168 grants and grant supplements worth $32.2 million were awarded. In 1981, these figures declined to only 67 grants and supplements totaling $17.4 million. No new grants have been awarded since 1981.

TABLE 1.—FEDERAL FINANCIAL SUPPORT FOR HMO DEVELOPMENT ACTIVITIES, FISCAL YEARS 1975–83

[Dollar amounts in millions]

Year	Loans and loan guarantees [1]		Grant assistance [2]		Total
	Number	Amount	Number	Amount	
1983	5	$6.96	0	0	$6.96
1982	11	18.54	0	0	18.54
1981	13	16.94	67	$17.43	34.37
1980	28	37.62	168	32.24	69.86
1979	29	44.17	180	20.96	67.13
1978	20	33.41	142	16.98	50.39
1977	18	36.17	71	16.95	53.12
1976	16	22.58	97	18.17	40.75
1975	2	2.44	179	22.46	24.90
Total	142	218.85	904	145.19	364.04

[1] Includes direct loans, direct loan supplements, loan guarantees and loan guarantee supplements. Source: 8th Annual Report to the Congress, Fiscal Year 1982, U.S. Department of Health and Human Resources, Office of Health Maintenance Organizations, p. 110.

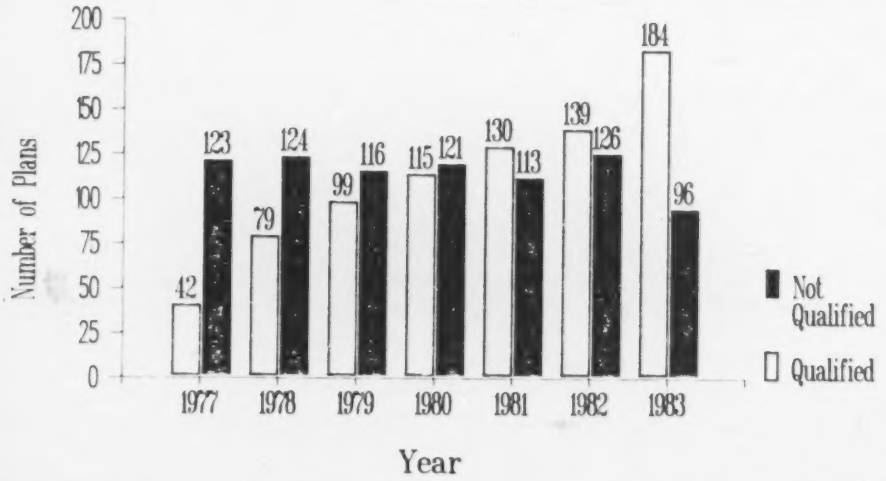
[2] Includes feasibility, planning and initial development grants. Source: 9th Annual Report to the Congress, Fiscal year 1983, U.S. Department of Health and Human Resoruces, Office of Health Maitenance Organizations, p. 145.

Between 1975 and 1983, the Federal program of loans and loan guarantees provided 132 direct loans and direct loan supplements valued at a total of $205 million, and ten loan guarantees for over $13 million. The loan activity peaked in 1979 with 21 direct loans, six direct loan supplements and two loan guarantees for a total value of over $44 million. In 1983, only three direct loans and two loan supplements, were awarded, for a total of $6.9 million. With the termination of all new federal financial assistance, there remains only one limited funding authorization, which expired with the end of fiscal year 1984. This is a loan fund established to cover any Federal losses under loans or loan guarantees already extended. As long as there remains the possibility of default on these loans, the contingency fund authority is necessary. The bill reauthorizes it for FY 1987, 1988 and 1989.

Despite the elimination of federal financial assistance, the number of both qualified and non-qualified plans has continued to rapidly expand, as shown in Figure 1. This figure also demonstrates that growth in the number of plans receiving Federal qualification has kept pace with the overall growth in the industry. Between 1975 and 1983, 219 HMO's were federally qualified, 184 of which were still in operation as of 1983 with an aggregate member-

ship of over 9 million. While federally qualified HMO's represented 59 percent of all prepaid health plans in 1983, they accounted for over 76 percent of all prepaid plans' memberships. According to Interstudy, the percent of all plans which are federally qualified increased to 63 percent in 1984.

Number of Prepaid Group Practices (HMOs) by Federal Qualification Status 1977–1983



Sources: 1979–83: 5th–9th Annual Reports to Congress, Fiscal Years 1979, 1980, 1981, 1982, and 1983. Department of Health and Human Services, Office of Health Maintenance Organizations. 1978: *National HMO Census of Prepaid Plans,* 1978, Department of Health, Education and Welfare, Office of Health Maintenance Organizations. 1977: *National HMO Census Survey—1977,* Group Health Association of America, Washington, D.C.

III. Text of S. 1762 and of H.R. 2417 as Amended

S. 1762

A BILL To amend the Public Health Service Act to revise and extend the program of assistance for health maintenance organizations

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That (a) this Act may be cited as the "Health Maintenance Organization Amendments of 1985".

(b) Whenever in this Act an amendment or repeal is expressed in terms of an amendment to, or a repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of the Public Health Service Act.

ELIMINATION OF AUTHORIZATION OF SUPPORT FOR FEASIBILITY SURVEYS, PLANNING, AND INITIAL DEVELOPMENT COSTS

SEC. (a) Sections 1303, 1304, and 1307(c) (42 U.S.C. 300e–2, 300e–3, and 300e–6(c)) are repealed.

(b)(1) Section 1306 (42 U.S.C. 300e–5) is amended—

(A) by striking out "grant, contract, loan," each place it appears (except in subsection (b)(6)) and inserting in lieu thereof "loan",

(B) by striking out "in the case of an application for assistance under section 1303 or 1304, such application meets the application requirements of such section and in the case of an application for a loan or loan guarantee," in subsection (b)(1),

(C) by striking out "1304," in subsection (b)(2), and

(D) by striking out "grants, contracts, loans," in subsection (c) and inserting in lieu thereof "loan".

(2) Section 1307 (42 U.S.C. 300e–6) is amended—

(A) by striking out "grant, contract, loan," each place it appears and inserting in lieu thereof "loan",

(B) by striking out "grant, contract, or" in subsection (a)(1), and

(C) by striking out "such assistance" in subsection (a)(1) and inserting in lieu thereof "the loan".

(3) Section 1309(a) U.S.C. 300e–8(a)) is amended—

(A) by striking out paragraph (1), and

(B) by striking out "(2)".

(4) The first sentence of section 1317(b) (42 U.S.C. 300e–16(b)) is amended—

(A) by striking out clause (1), and

(B) by redesignating clauses (2) and (3) as clauses (1) and (2), respectively.

(c) The amendments made by this section do not apply to any grant made or contract entered into under title XIII of the Public Health Service Act before October 1, 1985.

LIMITATION ON LOANS AND LOAN GUARANTEES FOR INITIAL COSTS OF OPERATION

SEC. 3. (a) The last sentence of section 1305(a) (42 U.S.C. 300e–4(a)) is amended by inserting before the period ", and unless the Secretary has made a grant or loan to, entered into a contract with, or guaranteed a loan for, the organization in fiscal year 1981, 1982, 1983, 1984, or 1985 under this section or section 1304(b) (as in effect before October 1, 1985".

(b) The amendment made by subsection (a) does not apply to any loan or loan guarantee for the initial costs of operation of a health maintenance organization made under title XIII of the Public Health Service Act before October 1, 1985.

ELIMINATION OF LOANS AND LOAN GUARANTEES FOR ACQUISITION AND CONSTRUCTION OF AMBULATORY CARE FACILITIES

SEC. 4. (a) Section 1305A (42 U.S.C. 300e–4a) is repealed.

(b) Section 1306(b)(2) (42 U.S.C. 300–5(b)(2)) is amended by striking out "or 1305A,".

(c) The amendments made by this section do not apply to any loan or loan guarantee made under section 1305A of the Public Health Service Act before October 1, 1985.

REPEAL OF REQUIREMENT FOR HEALTH SYSTEMS AGENCY REVIEW

SEC. 5. Section 1306(b) (42 U.S.C. 300e–5(b)) is amended by striking out paragraph (5) and by redesignating paragraphs (6), (7), and (8) as paragraphs (5), (6), and (7), respectively.

LIMITATION ON BORROWING BY LOAN GUARANTEE FUND

SEC. 6. The first sentence of section 1308(d)(2) (42 U.S.C. 300e–7(d)(2)) is amended by inserting "before October 1, 1986," after "guarantees issued by him".

REPEAL OF REQUIREMENT FOR PERIODIC DEMONSTRATION OF COMPLIANCE

SEC. 7. Section 1310(d) (42 U.S.C. 300e–9(d)) is amended by striking out the last sentence.

ANNUAL UPDATE OF STATE LAW DIGEST

SEC. 8. The first sentence of section 1311(c) (42 U.S.C. 300e–10(c)) is amended by striking out "quarterly" and inserting in lieu thereof "annually".

ELIMINATION OF UNNECESSARY REPORT

SEC. 9. Section 1318(e) (42 U.S.C. 300e–17(e)) is repealed.

AUTHORIZATION OF APPROPRIATIONS

SEC. 10. Section 1309(b) (42 U.S.C. 300e–8(b)) is amended to read as follows:

"(b) To meet the obligations of the loan fund established under section 1308(e) resulting from defaults on loans made from the fund and to meet the other obligations of the fund, there is authorized to be appropriated to the loan fund for fiscal years 1987, 1988, and 1989, such sums as may be necessary.".

ORGAN TRANSPLANTS AS PART OF BASIC COVERAGE

SEC. 11. (a) Section 1302(1) (42 U.S.C. 300e–1(1)) is amended by inserting before the last sentence the following new sentence: "Such term includes a health service directly associated with an organ transplant only if such organ transplant was required to be included in basic health services on April 15, 1985.".

(b)(1) The amendment made by subsection (a) shall take effect on October 1, 1985, and shall cease to be in effect on April 1, 1988.

(2) After April 1, 1988, for purposes of title XIII of the Public Health Service Act, no health service directly associated with an organ transplant shall be considered to be a basic health service if such service would otherwise have been added as a basic health service between April 15, 1985, and April 1, 1988.

STUDY ON THE HEALTH MAINTENANCE ORGANIZATION PROGRAM

SEC. 12. (a) The Secretary of Health and Human Services shall provide for the conduct of a study to assess the operation and impact of the provisons of title XIII of the Public Health Service Act. The study shall—

(1) assess the attitudes of employers and employees toward prepaid health benefits plans, particularly health maintenance organization plans;

(2) examine the operation of the community rating approach and the impact of such approach on the membership composition and competitiveness of health maintenance organizations qualified under such title;

(3) analyze the effects of the dual choice option provided in section 1310 of such Act on health maintenance organizations and on other health benefits plans;

(4) assess the approach used to add services no longer considered to be experimental to basic health services for health maintenance organizations qualified under such title, particularly with respect to the addition of organ transplants to such basic health services and the impact of such addition on the competitiveness of such health maintenance organizations;

(5) examine the effect of minimum benefit requirements, underwriting restrictions, restrictions on cost sharing, and the requirement that services be provided without limitation as to time or cost on the competitiveness of health maintenance organizations qualified under such title.

(b) within 18 months after the date of enactment of this Act, the Secretary shall prepare and transmit to the Congress a report which describes the findings and conclusions of the study conducted under subsection (a) and contains such recommendations for legislative and regulatory action as the Secretary considers appropriate.

(c) Any contract entered into under this section shall be to such extent or in such amounts as are provided in appropriation Acts.

SERVICES OF PSYCHOLOGISTS

SEC. 13. (a) Paragraphs (1) and (2) of section 1302 of the Public Health Service Act are amended by inserting "psychologist," after "podiatrist," each place it appears.

(b) Paragraph (4) of such section is amended by striking out "and podiatrists" and inserting in lieu thereof "podiatrists, and psychologists".

(c) Paragraph (5) of such section is amended by inserting "psychology," after "optometry,".

EFFECTIVE DATE

SEC. 14. (a) Except as provided in subsection (b) and section 11(b), this Act and the amendments made by this Act shall take effect on October 1, 1985.

(b) Section 12 shall take effect on the date of enactment of this Act.

CONSTRUCTION

SEC. 15. The provisions of this Act and of the amendments made by this Act do not authorize the appropriation of any funds for fiscal year 1986.

H.R. 2417

A BILL To amend the Public Health Service Act to revise and extend the program of assistance for health maintenance organizations

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE: REFERENCE TO ACT.

(a) SHORT TITLE.—This Act may be cited as the "Health Maintenance Organization Amendments of 1985".

(b) REFERENCE TO ACT.—Whenever in this Act an amendment or repeal is expressed in terms of an amendment to, or a repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of the Public Health Service Act.

SEC. 2. ELIMINATION OF AUTHORIZATION OF SUPPORT FOR FEASIBILITY SURVEYS, PLANNING, AND INITIAL DEVELOPMENT COSTS.

(a) IN GENERAL.—Sections 1303, 1304, and 1307(c) (42 U.S.C. 300e-2, 300e-3, and 300e-6(c)) are repealed.

(b) CONFORMING AMENDMENTS.—

(1) Section 1306 (42 U.S.C. 300e-5) is amended—

(A) by striking out "grant, contract, loan," each place it appears (except in subsection (b)(6)) and inserting in lieu thereof "loan",

(B) by striking out "in the case of an application for assistance under section 1303 or 1304, such application meets the application requirements of such section and in the case of an application for a loan or loan guarantee," in subsection (b)(1),

(C) by striking out "1304," in subsection (b)(2), and

(D) by striking out "grants, contracts, loans," in subsection (c) and inserting in lieu thereof "loans".

(2) Section 1307 (42 U.S.C. 300e-6) is amended—

(A) by striking out "grant, contract, loan," each place it appears and inserting in lieu thereof "loan",

(B) by striking out "grant, contract, or" in subsection (a)(1), and

(C) by striking out "such assistance" in subsection (a)(1) and inserting in lieu thereof "the loan".

(3) Section 1309(a) (42 U.S.C. 300e-8(a)) is amended—

(A) by striking out paragraph (1), and

(B) by striking out "(2)".

(4) The first sentence of section 1317(b) (42 U.S.C. 300e-16(b)) is amended—

(A) by striking out clause (1), and

(B) by redesignating clauses (2) and (3) as clauses (1) and (2), respectively.

(c) APPLICATION.—The amendments made by this section do not apply to any grant made or contract entered into under title XIII of the Public Health Service Act before October 1, 1985.

SEC. 3. LIMITATION ON LOANS AND LOAN GUARANTEES FOR INITIAL COSTS OF OPERATION.

(a) IN GENERAL.—The last sentence of section 1305(a) (42 U.S.C. 300e-4(a)) is amended by inserting before the period ", and unless the Secretary has made a grant or loan to, entered into a contract with, or guaranteed a loan for, the organization in fiscal year 1981, 1982, 1983, 1984, or 1985 under this section or section 1304(b) (as in effect before October 1, 1985)".

(b) APPLICATION.—The amendment made by subsection (a) does not apply to any loan or loan guarantee for the initial costs of operation of a health maintenance organization made under title XIII of the Public Health Service Act before October 1, 1985.

SEC. 4. ELIMINATION OF LOANS AND LOAN GUARANTEES FOR ACQUISITION AND CONSTRUCTION OF AMBULATORY CARE FACILITIES.

(a) IN GENERAL.—Section 1305A (42 U.S.C. 300e-4a) is repealed.

(b) CONFORMING AMENDMENT.—Section 1306(b)(2) (42 U.S.C. 300e-5(b)(2)) is amended by striking out "or 1305A,".

(c) APPLICATION.—The amendments made by this section do not apply to any loan or loan guarantee made under section 1305A of the Public Health Service Act before October 1, 1985.

SEC. 5. REPEAL OF REQUIREMENT FOR HEALTH SYSTEMS AGENCY REVIEW.

Section 1306(b) (42 U.S.C. 300e-5(b)) is amended by striking out paragraph (5) and by redesignating paragraphs (6), (7) and (8) as paragraphs (5), (6), and (7), respectively.

SEC. 6. LIMITATION ON BORROWING BY LOAN GUARANTEE FUND.

The first sentence of section 1308(d)(2) (42 U.S.C. 300e-7(d)(2)) is amended by inserting "before October 1, 1985," after "guarantees issued by him".

SEC. 7. REPEAL OF REQUIREMENT FOR PERIODIC DEMONSTRATION OF COMPLIANCE.

Section 1310(d) (42 U.S.C. 300e-9(d)) is amended by striking out the last sentence.

SEC. 8. ANNUAL UPDATE OF STATE LAW DIGEST.

The first sentence of section 1311(c) (42 U.S.C. 300e-10(C)) is amended by striking out "quarterly" and inserting in lieu thereof "annually".

SEC. 9. ELIMINATION OF UNNECESSARY REPORT.

Section 1318(e) (42 U.S.C. 300e-17(e)) is repealed.

SEC. 10. AUTHORIZATION OF APPROPRIATIONS.

Section 1309(b) (42 U.S.C. 300e-8(b)) is amended to read as follows:

"(b) To meet the obligations of the loan fund established under section 1308(e) resulting from defaults on loans made from the fund and to meet the other obligations of the fund, there is authorized to be appropriated to the loan fund for fiscal years 1987, 1988, and 1989, such sums as may be necessary.".

SEC. 11. ORGAN TRANSPLANTS AS PART OF BASIC COVERAGE.

Section 1302(1) (42 U.S.C. 300e-1(1)) is amended by inserting before the last sentence the following new sentence: "Such term includes a health service directly associated with an organ transplant only if such organ transplant was required to be included in basic health services on April 15, 1985.".

SEC. 12. EFFECTIVE DATE.

The amendments made by this Act shall take effect October 1, 1985.

IV. Hearings

A hearing before the full Committee on Labor and Human Resources was held on February 22, 1984 and oral testimony ws received from:

Dr. Edward N. Brandt, Assistant Secretary for Health, Department of Health and Human Services;

Mr. Michael Herbert, Speaker of the House of Delegates of the American Medical Care Review Association and President, Physician's Health Services, Trumbull, Connecticut; and

Mr. Robert Rasmussen, President of the Group Health Association of American and Executive Director of Prime Health Inc., Kansas City, Mo.

In addition written testimony was received from:

The Blue Cross and Blue Shield Association;

Dr. James P. Kerrigan, Chairman, Council of Legislation of the American Dental Association;

Dr. Melvin Sabshin, Medical Director for the American Psychiatric Association; and

Dr. Herbert Davis, Chairman, AV-Med Health Plan, Miami, Florida.

V. Committee Views

The provisions of S. 1762 are virtually identical to those of title IV of S. 2574, which was a package of five separate Public Health Service reauthorization bills. That bill was pocket vetoed by the President for reasons unrelated to the HMO amendments.

There was consensus that Congress should try again with a separate HMO bill this year, thus the House has taken last year's conference agreement on title IV and, with one change addressed to organ transplant coverage, has sent it to the Senate as H.R. 2417. That bill was referred to the Committee on Labor and Human Resources. S. 1762 follows the same approach, with the addition of a sunset provision for the organ transplant section, a new section directed to a study by the Department of Health and Human Services and a nonsubstantive amendment giving recognition to the work of psychologists in HMO's.

It is the Committee's intent that the text of S. 1762 be substituted for that of H.R. 2417 when the two are considered by the full Senate, and that H.R. 2417 as so amended be returned to the House.

S. 1762 as reported from Committee reauthorizes the remaining Federal operating fund—the contingency loan fund which expired

at the end of fiscal year 1984. Coupled with this reauthorization as a set of fine-tuning provisions which the Committee expects to streamline the operation of the law, reduce unnecessary regulation, and rid the statue of provisions which have outlived their usefulness.

S. 1762 confirms the Committee's view that the HMO industry is healthy, growing, and making a valuable contribution to the curbing of health costs across the country. Though the health services provider market is experiencing an unparalleled state of flux, the Committee feels that the federal HMO law needs only relatively minor adjustments at this time.

However, the HMO industry has continued at an unprecedented rate of expansion and at the same time other forms of health services providers have arisen and given challenge to the federal HMO concept.

Thus, the Committee feels a review of the basic elements and constrictions of the current law should be made to assess their impact and to identify changes which may result in increased competitiveness.

Section 12 of the bill directs the Secretary of Health and Human Services to provide for a study assessing the operation and impact of important parts of the title XIII Federal HMO program. The results of the study will enable the committee to determine if further changes in the Act are necessary. Areas for study include: the attitudes of employers and employees toward health maintenance organizations; the operation of community rating requirements and their impact on the HMO's competitiveness; analysis of the effects of the dual choice requirements of the Act on employers, HMOs and other providers; an examination of the approach used to require coverage by health maintenance organizations of services no longer considered experimental; and a study of the effect of other requirements, such as mandated benefits and restrictions on cost sharing, on HMOs' competitiveness. The committee expects the report to assess these issues and their impact on the increasingly competitive environment for employee health benefit plans.

In carrying out the study, the Committee expects the Secretary of Health and Human Services to seek the views of representatives of health maintenance organizations, other employee health benefit plans and providers and representatives of employer and labor about the execution of the study and any recommendations proposed.

The Committee expects the study to proceed expeditiously although no additional funds are authorized for FY 1986. Costs incurred in FY 1986 are to be absorbed from existing funds.

Secion 2 of the bill as reported repeals authority for initial planning and development grants, contracts and loans guarantees. No money has been appropriated for these activities in recent years. The Committee feels that HMO's now have sufficient access to the capital markets that there is no longer a need for this federal financial support.

Section 3 phases out similar support for initial costs of operation. The Office of Health Maintenance Organizations has informed the Committee that the last such loan was made in 1983, and this au-

thority as well is receiving no current appropriation. Again, the Committee feels this authority has become obsolete.

Section 4 repeals the authorization for federal support for the acquisition and construction of HMO ambulatory care facilities. This authority has never been funded, and it does not appear that a need for it exists.

Section 5 repeals the health systems agency review requirement for proposed federal financial support of HMO activities. Since there will be no new federal financial assistance under the statute as amended, there is no reason to carry over the review requirement. HMO's are already exempt from the health systems agencies' Certificate of Need review, as an expression of federal recognition of their cost saving and utilization limiting features. However, the Committee is disturbed at reports that in many states this exemption is being ignored, with the result that HMO activities are illegally hampered. The Committee expects the Department of Health and Human Services to offer full assistance to any HMO encountering this obstacle and to vigorously enforce the applicable federal restrictions on health systems agencies.

Section 6 simply conforms the Secretary's authority to borrow from the Treasury to cover defaults on federal loan guarantees to guarantees issued before October 1986.

Section 7 repeals the "requalification" requirement of the current law. The Committee feels the continuing montoring efforts by the Office of Health Maintenance Organizations are sufficiently organized and comprehensive to ensure compliance of federal HMO's with the requirements and standards of the statute. Thus, it believes that no weakening of compliance will result, and HMO's will be saved considerable time and expense, by the elimination of the periodic formal resubmission and requalification procedure.

Section 8 specifies that the digest of state laws and practices governing HMO's, which the Department is required to update quarterly, be updated instead of annually. The quarterly issuance schedule is an unusually short one, and it does not appear to be justified by either the frequency of change of the state laws or the urgency in use of the report.

Among the requirements applicable to federal HMO's are the financial disclosure provisions of Section 1318, designed to ensure that HMO's remain fiscally sound and that any dealings between HMO's and interested parties be at arm's length. The Department is directed to publish an annual report on its activities and findings in this regard. While the Committee values the oversight called for under section 1318, it does not appear that use of the report itself justifies the expense of compiling and publishing it. Thus, section 9 of the bill repeals the requirement for the report. However, the Committee expects that the information collected in the continuing monitoring of these activities and of the financial condition of HMO's will continue to be made available upon request.

Section 10 of the bill reauthorizes the contingency loan default fund mentioned earlier.

Section 11 amends the basic health coverage requirements for federally qualified HMO's. Under the law as currently interpreted, HMO's must add to their "basic health services" coverage for ex-

perimental medical procedures that become accepted medical practice, that is, which are no longer experimental.

In recent years the advent of cyclosporins and of improved medical practice has resulted in the passage from "experimental" to "medically accepted" of a number of organ transplant procedures, including kidney transplants and liver transplants for children. It appears that in the near future, other procedures, such as heart-lung transplants, may become medically accepted. Because of the enormous expense involved with such procedures, federally qualified HMO's fear a crisis. They have become concerned that forced coverage of transplants in their basic benefits package will so raise their rates that they will be placed at a serious competitive disadvantage in an increasingly competitive health care marketplace. Other providers and insurers are free to offer their transplant coverage as supplemental packages, for which additional premiums are charged, allowing them to keep their basic coverage rates lower.

The Committee is sensitive to the federal HMOs' problem, and concurs with the House language, which prevents the forced coverage of new types of transplants and allows them to be covered instead as supplemental benefits. However, the Committee has not held hearings on this point, and is willing to grant the industry an open-ended exception. Thus Section 11 is effective for only thirty months, at which time Congress will reconsider the question. Transplant procedures currently required to be treated as basic health services will continue to be so—only future additions to the list will be affected.

And in the interim, the study of this issue provided for in Section 12 will have been completed and the Committee will be in a better position to assess how to handle on a long-term basis the issue of new transplant procedures. In the event the exemption expires without prior action by Congress, federally qualified HMO's would, thereafter, be at risk of mandated coverage only for procedures subsequently moving from the "experimental" to "accepted" category, not for those which become accepted during the interim.

In requiring coverage for future transplants in the case of such an expiration, the Committee expects the Secretary to provide a reasonable phase-in period. In determining the length of the period, consideration should be given to HMO budgeting cycles, member contract renewal dates, and limitations on the manner in which federally qualified HMO's establish their rates. Adequate time should be provided so that HMOs can adjust their rates and coordinate the necessary personnel and facilities in an orderly manner.

The Committee notes that the inclusion of this provision in Title 13 of the Public Health Service Act does not alter the authority of states to requires HMO's to cover organ transplants under state law.

Section 12 provides for the study of key portions of Title XIII as outlined earlier.

Sectioin 13 contains an amendment adding psychologists to the list of health professionals, such as dentists, optometrists, and podiatrists, set forth in several places in the statute. The current language, "other health care professional" encompasses psychologists

in practice, and their inclusion among those specifically mentioned does not change the operation of the law in any way. Instead, it highlights the invaluable contribution of psychologists to the comprehensive treatment of the patient under title XIII.

Section 14 provides the effective dates for the amendments.

Section 15 provides that the amendments authorize no additional appropriations for FY 1986.

Finally, it is the Committee's view that the broad variety of services mandated under Title XIII does not define the full range of services which may best serve an individual's needs. Thus federal H.M.O.'s are encouraged to augment that coverage with appropriate treatment not necessarily required under the terms of Title XIII, through supplemental benefits packages, for example. In particular, while current law requires provision of a minimum number of outpatient visits for psychiatric care, it is the sense of the Committee that the nature of serious mental illness is such that inpatient mental treatment is often the most cost-effective and appropriate course. It is the Committee's intent to encourage federally qualified H.M.O.'s to favorably consider providing such treatment under their health care plans, pending the review of the larger issue of mandated benefits called for in the study to be conducted by the Secretary of Health and Human Services.

VI. Votes in Committee

S. 1762 and H.R. 2417 were brought up for markup at the Committee Executive Session on November 19, 1985. At that time an amendment by Senator Wallop was debated, which would have stricken the "dual choice" authority conferred by section 1310 of Title XIII. That amendment was defeated in a voice vote.

An amendment was also proposed by Senator Wallop which would have, in effect, repealed the federal HMO program. This amendment was defeated by a vote as follows:

YEAS	NAYS
Nickles	Hatch
Thurmond	Quayle
Wallop	Hawkins
	Weicker
	Grassley
	Pell
	Metzenbaum
	Matsunaga
	Dodd
	Simon
	Kerry
	Stafford
	Kennedy

Following defeat of this amendment, both S. 1762 and H.R. 2417 were ordered reported favorably from committee by a vote of 14 to 2, as follows:

YEAS	NAYS
Hatch	Wallop
Quayle	Nickles
Hawkins	
Thurmond	
Weicker	
Grassley	
Pell	
Metzenbaum	
Matsunaga	
Dodd	
Simon	
Kerry	
Kennedy	
Stafford	

VII. Cost Estimate

U.S. Congress,
Congressional Budget Office,
Washington, DC, December 13, 1985.

Hon. Orrin G. Hatch,
Chairman, Committee on Labor and Human Resources, U.S. Senate, Washington, DC.

Dear Mr. Chairman: The Congressional Budget Office has prepared the attached revised cost estimate for S. 1762, the Health Maintenance Organization Amendments of 1985, as ordered reported by the Senate Committee on Labor and Human Resources on November 19, 1985.

If you wish further details on this estimate, we will be pleased to provide them.

With best wishes,
Sincerely,

James Blum
(For Rudolph G. Penner).

CONGRESSIONAL BUDGET OFFICE COST ESTIMATE

1. Bill number: S. 1762.
2. Bill title: Health Maintenance Organization Amendments of 1985.
3. Bill status: As ordered reported by the Senate Committee on Labor and Human Resources on November 19, 1985.
4. Bill purpose: To amend the Public Health Service Act to revise the programs of assistance for health maintenance organizations.
5. Estimated cost to the Federal Government:

[By fiscal years, in millions of dollars]

	1986	1987	1988	1989	1990
Estimated authorization level:					
Lean fund					
Study		0.2			
Total estimated authorization level		0.2			

[By fiscal years, in millions of dollars]

	1986	1987	1988	1989	1990
Estimated outlays:					
Loan fund					
Study		0.2			
Total estimated outlays		0.2			

The costs of this bill fall within function 550.

Basis of Estimate: This bill would repeal the authorizing language for grants and contracts to fund initial development costs incurred by health maintenance organizations (HMO). The HMO Loan and Loan Guarantee Fund made its last loan and loan guarantee in 1983.

The bill authorizes such sums as may be necessary in fiscal year 1987 through 1989 to meet the obligations of the Fund. These obligations would result mainly from defaults on loans previously made by the Fund. Based on information provided by the HMO Loan and Loan Guarantee Fund, CBO expects that no defaults will occur in 1987 through 1989. Should defaults occur, appropriations for the Fund would be needed.

The bill would also amend current law provisions concerning HMO coverage of organ transplants. Currently, HMO's are required to cover all organ transplants that are not experimental. S. 1762 would have HMO's continue to cover transplants that are currently required, but would allow them to elect to cover any new, non-experimental transplants.

The bill would require the Secretary of HHS to conduct a study assessing the impact of Title XIII on the competitiveness of HMO's. No cost is included in this estimate for the study in fiscal year 1986 as the bill specifically states that its provisions do not authorize the appropriation of any funds for fiscal year 1986. We assume that two full-time equivalents would be needed in 1987 to conduct the eighteen-month study, costing the government about $200,000.

6. Estimated cost to State and local government: The budgets of state and local governments will not be affected directly by the enactment of this bill.

7. Estimate comparison: None.

8. Previsous CBO estimate: CBO prepared an estimate for this bill on December 3, 1985. In that estimate, the costs of the study were split between fiscal years 1986 and 1987. The Committee has since added a section to the bill stating that appropriations are not authorized in fiscal year 1986. All the costs of the study in this estimate appear in fiscal year 1987.

CBO prepared an estimate on May 20, 1985 of H.R. 2417, the Health Maintenance Organization Amendments of 1985, as ordered reported by the House Committee on Energy and Commerce. Costs of $2.5 million in 1986 and $1.5 million in 1987 through 1990 were shown in that estimate to cover one to two expected defaults in the program each year. The HMO Loan and Loan Guarantee program has since revised these estimates, expecting no defaults in the projection period. Appropriations would be needed to cover any unanticipated defaults.

9. Estimate prepared by: Carmela Dyer.

10. Estimate approved by: C.G. Nuckols (for James L. Blum, Assistant Director for Budget Analysis).

VIII. Regulatory Impact Statement

The Committee has determined that there will be a net decrease in regulatory burden and paperwork as a result of this bill. Three provisions in this bill will have the specific effect of reducing the regulatory and paperwork burden. Federally qualified HMOs will not have to periodically requalify as previously required. The digest of State HMO laws will only be updated annually instead of quarterly. Finally, although the bill maintains the Department's monitoring function of the implementation of financial disclosure requirements, the Secretary will not have to make annual reports to Congress on that function. No other provisions in this bill are expected to have any impact on the regulatory burden or amount of paperwork required.

IX. Family Fairness Statement

The Committee has determined that this bill does not have a direct impact on family functions. Its amendments are basically technical and accomplish minor program improvements in the administration and operation of Title XIII of the Public Health Service Act. Title XIII, through its encouragement of quality HMO's of comprehensive scope, does indirectly aid families to gain access to a broad range of health services, including preventive health services, at a reasonable fixed rate.

X. Section-by-Section Analysis

Section 2 eliminates federal support for HMO's feasibility surveys, planning, and initial development costs. These activities are no longer being funded.

Section 3 phases out federal loans and loan guarantees for the initial cost of operation of an HMO by limiting that assistance to HMO's which received such loans or loan guarantees, or received federal support for initial development costs, in fiscal 1981, 1982, 1983, 1984, or 1985.

Section 4 eliminates the authorization for federal loans and loan guarantees for the acquisition and construction of HMO ambulatory care facilities. This authority has never been operational.

Section 5 eliminates the requirements for review by a health systems agency (the local health planning agency) of any proposed federal support of HMO activities. HMO's are already exempt from these agencies' Certificate of Need Review.

Section 6 limits the authority of the Secretary to borrow from the Treasury to meet obligations of the loan fund to instances in which borrowing is necessary to meet guarantees issued before October, 1986.

Section 7 repeals the requirement that an HMO periodically demonstrate to the Secretary that it continues to meet the federal requirements for HMO's. Under other provisions of law, HMO's are required to submit reports and are subject to examination.

Section 8 amends the requirement that a digest of state HMO laws and regulations be maintained and updated to require updating annually rather than quarterly.

Section 9 repeals the requirement that the Secretary report annually to Congress on implementation of the financial disclosure requirements, but maintains the Department's monitoring of that implementation.

Section 10 reauthorizes the Section 1308(e) loan fund for FY 1987, 1988 and 1989.

Section 11 provides that federal HMO's will not be required to add new organ transplant procedures to their basic health benefits packages between April 15, 1985 and April 1, 1988.

Section 12 requires the Secretary of Health and Human Services to provide for a study to assess the operation and impact of important aspects of title XIII.

Section 13 adds the term "psychologist" to the list of health professionals set forth at various places in the statute.

Section 14 specifies the effective dates for the provisions of the Act.

Section 15 provides that the amendments do not authorize any additional funds for FY 1986.

XI. Changes in Existing Law

In compliance with rule XXVI paragraph 12 of the Standing Rules of the Senate, the following provides a print of the statute or the part or section thereof to be amended or replaced by S. 1762 (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

Public Health Service Act

TITLE I—SHORT TITLE AND DEFINITIONS

SHORT TITLE

Section 1. This Act may be cited as the "Public Health Service Act."

* * * * * * *

TITLE XIII—HEALTH MAINTENANCE ORGANIZATIONS

REQUIREMENTS FOR HEALTH MAINTENANCE ORGANIZATIONS

Sec. 1301. (a) For purposes of this title, the term "health maintenance organization" means a legal entity which (1) provides basic and supplemental health services to its members in the manner prescribed by subsection (b), and (2) is organized and operated in the manner prescribed by subsection (c).

(b) A health maintenance organization shall provide, without limitations as to time or cost other than those prescribed by or under this title, basic and supplemental health services to its members in the following manner:

(1) Each member is to be provided basic health services for a basic health services payment which (A) is to be paid on a periodic basis without regard to the dates health services (within the basic health services) ae provided; (B) is fixed without regard to the frequency, extent, or kind of health service (within the basic health services) actually furnished; (C) except in the case of basic health services provided a member who is a full-time student (as defined by the Secretary) at an accredited institution of higher education, is fixed under a community rating system; and (D) may be supplemented by additional nominal payments which may be required for the provision of specific services (within the basic health services), except that such payments may not be required where or in such a manner that they serve (as determined under regulations of the Secretary) as a barrier to the delivery of health services. Such additional nominal payments shall be fixed in accordance with the regulations of the Secretary. A health maintenance organization may include a health service, defined as a supplemental health service by section 1302(2), in the basic health services provided its members for a basic health services payment described in the first sentence. In the case of an entity which before it becomes a qualified health maintenance organization (within the meaning of section 1310(d)) provided comprehensive health services on a prepaid basis the requirement of clause (C) shall not apply to such entity until the expiration of the forty-eight month period beginning with the month following the month in which the entity became such a qualified health organization. The requirements of this paragraph respecting the basic health services payment shall not apply to the provision of basic health services to a member for an illness or injury for which the member is entitled to benefits under a workmen's compensation law or an insurance policy but only to the extent such benefits apply to such services. For the provision of such services for an illness or injury for which a member is entitled, to benefits under such a law, the health maintenance organization may, if authorized by such law, charge or authorize the provider of such services to charge, in accordance with the charges allowed under such law, the insurance carrier, employer, or other entity which under such law is to pay for the provision of such services, or, to the extent that such member has been paid under such law for such services, such members. For the provision of such services for an illness or injury for which a member is entitled to benefits under an insurance policy, a health maintenance organization may charge or authorize the provider of such services to charge the insurance carrier under such policy or, to the extent that such member has been paid under such policy for such services, such member.

(2) For such payment or payments (hereinafter in this title referred to as "supplemental health service payments") as the health maintenance organization may require in addition to the basic health services payment, the organization may provide to each of its members any of the health services which are included in supplemental health service (as defined in sec-

tion 1302(2)). Supplemental health services payments which are fixed on a prepayment basis shall be fixed under a community rating system unless the supplemental health services payment is for a supplemental health service provided a member who is a full-time student (as defined by the Secretary) at an accredited institution of higher education, except that, in the case of an entity which before it became a qualified health maintenance organization (within the meaning of section 1310(d)) provided comprehensive health services on a prepaid basis, the requirement of this sentence shall not apply to such entity during the forty-eight month period beginning with the month following the month in which the entity became such a qualified health maintenance organization.

(3)(A) Except as provided in subparagraph (B) the services of a physician which are provided as basic health services shall be provided through—

(i) members of the staff of the health maintenance organization.

(ii) a medical group (or groups),

(iii) an individual practice association (or associations),

(iv) physicians or other health professionals who have contracted with the health maintenance organization for the provision of such services, or

(v) any combination of such staff, medical group (or groups), individual practice association (or associations) or physicians or other health professionals under contract with the organization.

(B) Subparagraph (A) does not apply to the provision of the services of a physician—

(i) which the health maintenance organization determines, in conformity with regulations of the Secretary, are unusual or infrequently used, or

(ii) which are provided a member of the organization in a manner other than that prescribed by subparagraph (A) because of an emergency which made it medically necessary that the service be provided to the member before it could be provided in a manner prescribed by subparagraph (A).

(C) Contracts between a health maintenance organization and health professionals for the provision of basic and supplemental health services shall include such provisions as the Secretary may require (including provisions requiring appropriate continuing education).

(D) Contracts between a health maintenance organization and health professionals for the provision of basic and supplemental health services shall include such provisions as the Secretary may require, but only to the extent that such requirements are designed to insure the delivery of quality health care services and sound fiscal management.

(4) Basic health services (and only such supplemental health services as members have contracted for) shall within the area served by the health maintenance organization be available and accessible to each of its member with reasonable promptness and in a manner which assures continuity, and when

medically necessary be available and accessible twenty-four hours a day and seven days a week, except that a health maintenance organization which has a service area located wholly in a nonmetropolitan area may make a basic health service available outside its service area if that basic health service is not a primary care or emergency health care service and if there is an insufficient number of providers of that basic health service within the service area who will provide such service to members of the health maintenance organization. A member of a health maintenance organization shall be reimbursed by the organization for his expenses in securing basic and supplemental health services other than through the organization if the services were medically necessary and immediately required because of an unforeseen illness, injury, or condition.

(5) To the extent that a natural disaster, war, riot, civil insurrection, or any other similar event not within the control of a health maintenance organization (as determined under regulations of the Secretary) results in the facilities, personnel, or financial resources of a health maintenance organization not being available to provide or arrange for the provision of a basic or supplemental health service in accordance with the requirements of paragraphs (1) through (4) of this subsection, such requirements only require the organization to make a good-faith effort to provide or arrange for the provision of such service within such limitation on its facilities, personnel, or resources.

(c) Each health maintenance organization shall—

(1)(A) have a fiscally sound operation and adequate provision against the risk of insolvency which is satisfactory to the Secretary, and (B) have administrative and managerial arrangements satisfactory to the secretary;

(2) assume full financial risk on a prospective basis for the provisions of basic health services, except that a health maintenance organization may (A) obtain insurance or make other arrangements for the cost of providing to any member basic health services the aggregate value of which exceeds $5,000 in any year, (B) obtain insurance or make other arrangements for the cost of basic health services provided to its members other than through the organization because medical necessity required their provision before they could be secured through the organization, (C) obtain insurance or make other arrangements for not more than 90 per centum of the amount by which its costs for any of its fiscal years exceed 115 per centum of its income for such fiscal year, and (D) make arrangements with physicians or other health professionals, health care institutions, or any combination of such individuals or institutions to assume all or part of the financial risk on a prospective basis for the provision of basic health services by the physicians or other health professionals or through the institutions;

(3)(A) enroll persons who are broadly representative of the various age, social, and income groups within the area it serves, except that in the case of a health maintenance organization which has a medically underserved population located

(in whole or in part) in the area it serves, not more than 75 per centum of the members of that organization may be enrolled from the medically underserved population unless the area in which such population resides is also a rural area (as designated by the Secretary), and (B) carry out enrollment of members who are entitled to medical assistance under a State plan approved under title XIX of the Social Security Act in accordance with procedures approved under regulations promulgated by the Secretary;

(4) not expel or refuse to re-enroll any member because of his health status or his requirements for health services;

(5)(A) in the case of a private health maintenance organization, be organized in such a manner that assures that (i) at least one-third of the membership of the policymaking body of the health maintenance organization will be members of the organization, and (ii) there will be equitable representation on such body of members from medically underserved populations served by the organization, and (B) in the case of a public health maintenance organization, have an advisory board to the policymaking body of the public entity operating the organization which board meets the requirements of clause (A) of this paragraph and to which may be delegated policymaking authority for the organization;

(6) be organized in such a manner that provides meaningful procedures for hearing and resolving grievances between the health maintenance organization (including the medical group or groups and other health delivery entities providing health services for the organization) and the members of the organization;

(7) have organizational arrangements, established in accordance with regulations of the Secretary, for an ongoing quality assurance program for its health services which program (A) stresses health outcomes, and (B) provides review by physicians and other health professionals of the process followed in the provision of health services;

(8) adopt at least one of the following arrangements to protect its members from incurring liability for payment of any fees which are the legal obligation of such organization—

(A) a contractual arrangement with any hospital that is regularly used by the members of such organization prohibiting such hospital from holding any such member liable for payment of any fees which are the legal obligation of such organization;

(B) insolvency insurance, acceptable to the Secretary;

(C) adequate financial reserve, acceptable to the Secretary; and

(D) other arrangements, acceptable to the Secretary to protect members,

except that the requirements of this paragraph shall not apply to a health maintenance organization if applicable State law provides the members of such organization with protection from liability for payment of any fees which are the legal obligation of such organization; and

(9) provide, in accordance with regulations of the Secretary (including safeguards concerning the confidentiality of the doctor-patient relationship), an effective procedure for developing, compiling, evaluating, and reporting to the Secretary, statistics and other information (which the Secretary shall publish and disseminate on an annual basis and which the health maintenance organization shall disclose, in a manner acceptable to the Secretary, to its members and the general public) relating to (A) the cost of its operations, (B) the patterns of utilization of its services, (C) the availability, accessibility, and acceptability of its services, (D) to the extent practical, developments in the health status of its members, and (E) such other matters as the Secretary may require.

DEFINITIONS

SEC. 1302. For purposes of this title:

(1) The term "basic health services" means—

(A) physician services (including consultant and referral services by a physician);

(B) inpatient and outpatient hospital services;

(C) medically necessary emergency health services;

(D) short-term (not to exceed twenty visits), outpatient evaluative and crisis intervention mental health services;

(E) medical treatment and referral services (including referral services to appropriate ancillary services) for the abuse of or addiction to alcohol and drugs;

(F) diagnostic laboratory and diagnostic and therapeutic radiologic services;

(G) home health services; and

(H) preventive health services (including (i) immunizations, (ii) well-child care from birth, (iii) periodic health evaluations for adults, (iv) voluntary family planning services, (v) infertility services, and (vi) children's eye and ear examinations conducted to determine the need for vision and hearing correction).

Such term does not include a health service which the Secretary, upon application of a health maintenance organization, determines is unusual and infrequently provided and not necessary for the protection of individual health. The Secretary shall publish in the Federal Register each determination made by him under the preceding sentence. If a service of a physician described in the preceding sentence may also be provided under applicable State law by a dentist, optometrist, podiatrist, *psychologist,* or other health care personnel a health maintenance organization may provide such service through a dentist, optometrist, podiatrist, *psychologist,* or other health care personnel (as the case may be) licensed to provide such service.

Such term includes a health service directly associated with an organ transplant only if such organ transplant was required to be included in basic health services on April 15, 1985.

For purposes of this paragraph, the term "home health services" means health services provided at a member's home by health care personnel, as prescribed or directed by the responsible physician or

other authority designated by the health maintenance organization.

(2) The term "supplemental health services" means any health service which is not included as a basic health service under paragraph (1) of this section. If a health service provided by a physician may also be provided under applicable State law by a dentist, optometrist, podiatrist, *psychologist,* or other health care personnel, a health maintenance organization may provide such service through an optometrist, dentist, podiatrist, *psychologist,* or other health care personnel (as the case may be) licensed to provide such service.

(3) The term "member" when used in connection with a health maintenance organization means an individual who has entered into a contractual agreement, or on whose behalf a contractual arrangement has been entered into, with the organization under which the organization assumes the responsibility for the provision to such individual of basic health services and of such supplemental health services as may be contracted for.

(4) The term "medical group" means a partnership, association, or other group—

(A) which is composed of health professionals licensed to practice medicine or osteopathy and of such other licensed health professionals (including dentists, optometrists, *podiatrists, and psychologists*) as are necessary for the provision of health services for which the group is responsible;

(B) a majority of the members of which are licensed to practice medicine or osteopathy; and

(C) the members of which (i) as their principal professional activity engage in the coordinated practice of their profession and as a group responsibility have substantial responsibility for the delivery of health services to members of a health maintenance organization, except that this clause does not apply before the end of the forty-eight month period beginning after the moth in which the health maintenance organization becomes a qualified health maintenance organization as defined in section 1310(d), or as authorized by the Secretary in accordance with regulations that take into consideration the usual circumstances of the group; (ii) pool their income from practice as members of the group and distribute it among themselves according to a prearranged salary or drawing account or other similar plan unrelated to the provision of specific health services; (iii) share medical and other records and substantial portions of major equipment and of professional, technical, and administrative staff; (iv) arrange for and encourage continuing education in the field of clinical medicine and related areas for the members of the group; and (v) establish an arrangement whereby a member's enrollment status is not known to the health professional who provides health services to the member.

(5) The term "individual practice association" means a partnership, corporation, association, or other legal entity which has entered into a services arrangement (or arrangements) with persons who are licensed to practice medicine, osteopathy, dentistry, podiatry, optometry, *psychology,* or other health profession in a State

and a majority of whom are licensed to practice medicine or osteopathy. Such an arrangement shall provide—

(A) that such person shall provide their professional services in accordance with a compensation arrangement established by the entity; and

(B) to the extent feasible, for the sharing by such persons of medical and other records, equipment, and professional, technical, and administrative staff.

(6) The term "health systems agency" means an entity which is designated in accordance with section 1515 of this Act.

(7) The term "medically underserved population" means the population of an urban or rural area designated by the Secretary as an area with a shortage of personal health services or a population group designated by the Secretary as having a shortage of such services. Such a designation may be made by the Secretary only after consideration of the comments (if any) of (A) each State health planning and development agency which covers (in whole or in part) such urban or rural area or the area in which such population group resides, and (B) each health systems agency designated for a health service area which covers (in whole or in part) such urban or rural area or the area in which such population group resides.

(8)(A) The term "community rating system" means the systems, described in subparagraphs (B) and (C), of fixing rates of payments for health services. A health maintenance organization may fix its rates of payment under the system described in subparagraph (B) or (C) or under both such systems, but a health maintenance organization may use only one such system for fixing its rates of payments for any one group.

(B) A system of fixing rates of payment for health services may provide that the rates shall be fixed on a per-person or per-family basis and may authorize the rates to very with the number of persons in a family, but, except as authorized in subparagraph (D), such rates must be equivalent for all individuals and for all families of similar composition.

(C) A system of fixing rates of payment for health services may provide that the rates shall be fixed for individuals and families by groups. Except as authorized in subparagraph (D), such rates must be equivalent for all individuals in the same group and for all families of similar composition in the same group. If a health maintenance organization is to fix rates of payment for individuals and families by groups, it shall—

(i) classify all of the members of the organization into classes based on factors which the health maintenance organization determines predict the differences in the use of health services by the individuals or families in each class and which have not been disapproved by the Secretary,

(ii) determine its revenue requirements for providing services to the members of each class established under clause (i), and

(iii) fix the rates of payment for the individuals and families of a group on the basis of a composite of the organization's revenue requirements determined under clause (ii) for providing services to them as members of the classes established under clause (i).

The Secretary shall review the factors used by each health maintenance organization to establish classes under clause (i). If the Secretary determines that any such factor may not reasonably be used to predict the use of the health services by individuals and families, the Secretary shall disapprove such factor for such purpose.

(D) The following differentials in rates of payments may be established under the systems described in subparagraphs (B) and (C):

(i) Nominal differentials in such rates may be established to reflect differences in marketing costs and the different administrative costs of collecting from the following categories of members:

(I) Individual members (including their families).

(II) Small groups of members (as determined under regulations of the Secretary).

(III) Large groups of members (as determined under regulations of the Secretary).

(ii) Nominal differentials in such rates may be established to reflect the compositing of the rates of payment in a systematic manner to accommodate group practices of the various employers.

(iii) Differentials in such rates may be established for members enrolled in a health maintenance organization pursuant to a contract with a governmental authority under section 1079 or 1086 of title 10, United States Code, or under any other governmental program (other than the health benefits program authorized by chapter 89 of title 5, United States Code) or any health benefits program for employees of States, political subdivision of States, and other public entities.

(9) The term "non-metropolitan area" means an area no part of which is within an area designated as a standard metropolitan statistical area by the Office of Management and Budget and which does not contain a city whose population exceeds fifty thousand individuals.

[GRANTS AND CONTRACTS FOR FEASIBILITY SURVEYS

[SEC. 1303. (a) The Secretary may make grants to and enter into contracts with public or nonprofit entities for projects for surveys or other activities to determine the feasibility of developing and operating or expanding the operation of health maintenance organizations.

[(b) An application for a grant or contract under this section shall contain—

[(1) assurances satisfactory to the Secretary that, in conducting surveys or other activities with assistance under a grant or contract under this section, the applicant will (A) cooperate with each health systems agency designated for a health service area which covers (in whole or in part) the area for which the survey or other activity will be conducted, and (B) notify the medical society serving such area of such surveys or other activities; and

[(2) such other information as the Secretary may by regulation prescribe.

[(c) In considering applications for grants and contracts under this section, the Secretary shall give priority to an application which contains or is supported by assurances satisfactory to the Secretary that at the time the health maintenance organization for which such application or proposal is submitted first becomes operational not less than 30 per centum of its members will be members of a medically underserved population.

[(d)(1) Except as provided in paragraph (2), the following limitations apply with respect to grants and contracts made under this section:

[(A) If a project has been assisted with a grant or contract under subsection (a), the Secretary may not make any other grant or enter into any other contract under this section for such project.

[(B) Any project for which a grant is made or contract entered into must be completed within twelve months from the date the grant is made or contract entered into.

[(2) The Secretary may make not more than one additional grant or enter into not more than one additional contract for a project for which a grant has previously been made or a contract previously entered into, and he may permit additional time (up to twelve months) for completion of the project if he determines that the additional grant or contract (as the case may be), or additional time, or both, is needed to adequately complete the project.

[(e) The amount to be paid by the United States under a grant made, or contract entered into, under subsection (a) shall be determined by the Secretary, except that (1) the amount to be paid by the United States under any single grant or contract for any project may not exceed $75,000, and (2) the aggregate of the amounts to be paid by the United States for any project under such subsection under grants or contracts, or both, may not exceed the greater of (A) 90 per centum of the costs of such project (as determined under regulations of the Secretary), or (B) in the case of a project for a health maintenance organization which will serve a medically underserved population, such greater percentage (up to 100 per centum) of such costs as the Secretary may prescribe if he determines that the ceiling on the grants and contracts for such project should be determined by such greater percentage.

[(f) Payments under grants under this section may be made in advance or by way of reimbursement and at such intervals and on such conditions as the Secretary finds necessary.

[(g) Contracts may be entered into under this section without regard to section 3648 and 3709 of the Revised Statutes (31 U.S.C. 529; 41 U.S.C. 5).

[(h) Payments under grants and contracts under this section shall be made from appropriations made under section 1309(a).] [Repealed.]

[GRANTS, CONTRACTS, AND LOAN GUARANTEES FOR PLANNING AND FOR INITIAL DEVELOPMENT COSTS

[SEC. 1304. (a) The Secretary may—

[(1) make grants to and enter into contracts with public or nonprofit private entities for planning projects for the estab-

lishment of health maintenance organizations or for the significant expansion of the membership of, or areas served by, health maintenance organizations; and

[(2) guarantee to non-Federal lenders payment of the principal of and the interest on loans made to—

[(A) nonprofit private entities for planning projects for the establishment or expansion of health maintenance organizations, or

[(B) other private entities for such projects for health maintenance organizations which will serve medically underserved populations.

Planning projects assisted under this subsection shall include development of plans for the marketing of the services of the health maintenance organization.

[(b)(1) The Secretary may—

[(A) make grants to and enter into contracts with public or nonprofit private entities for projects for the initial development of health maintenance organizations; and

[(B) guarantee to non-Federal lenders payment of the principal of and the interest on loans made to—

[(i) nonprofit private entities for projects for the initial development of health maintenance organizations, or

[(ii) other private entities for such projects for health maintenance organizations which will serve medically underserved populations.

[(2) For purposes of this section, the term "initial development" when used to describe a project for which assistance is authorized by this subsection means the establishment of a health maintenance organization, the expansion of the services of a health maintenance organization, or the significant expansion of the membership of, or the area served by, a health maintenance organization. Funds under grants and contracts under this subsection and under loans guaranteed under this subsection may only be utilized for such purposes as the Secretary may prescribe in regulations. Such purposes may include (A) the implementation of an enrollment campaign for such an organization, (B) the detailed design of an arrangements for the health services to be provided by such an organization, (C) the development of administrative and internal organizational arrangements, including fiscal control and fund accounting procedures, and the development of a capital financing program, (D) the recruitment of personnel who will engage in practice principally for the health maintenance organization and the conduct of training activities for such personnel, and (E) the payment of architects' and engineers' fees.

[(3) A grant or contract under this subsection may only be made or entered into for initial development costs incurred in a period not to exceed three years from the first day of the first month in which such grant or contract is made or entered into. A loan guarantee under this subsection may only be made for a loan (or loans) for such costs incurred in a period not to exceed three years.

[(4) A health maintenance organization which is a qualified health maintenance organization within the meaning of section 1310(d) may receive, in accordance with paragraph (1), a grant, con-

tract, or loan guarantee for the expansion of its services or the significant expansion of its membership or the area served by it.

[(c)(1) An application for a grant, contract, or loan guarantee under subsection (a) for a planning project shall contain assurances satisfactory to the Secretary that in carrying out the planning project for which the grant, contract, or loan guarantee is sought, the applicant will (A) cooperate with each health systems agency designated for a health service area which covers (in whole or in part) the area proposed to be served by the health maintenance organization for which the planning project will be conducted, and (B) notify the medical society serving such area of the planning project.

[(2) If the Secretary makes a grant or loan guarantee or enters into a contract under subsection (a) for a planning project for a health maintenance organization, he may, within the period in which the planning project must be completed, make a grant or loan guarantee or enter into a contract under subsection (b) for the initial development of that health maintenance organization; but no grant or loan guarantee may be made or contract entered into under subsection (b) for initial development of a health maintenance organization unless the Secretary determines that (A) sufficient planning for its establishment or expansion (as the case may be) has been conducted by the applicant for the grant, contract, or loan guarantee, and (B) the feasibility of establishing and operating, or of expanding, the health maintenance organization has been establish by the applicant.

[(d) In considering applications for grants and contracts under this section, the Secretary shall give priority to an application which contains or is supported by assurances satisfactory to the Secretary that at the time the health maintenance organization for while such application is submitted first becomes operational not less than 30 per centum of its members will be members of a medically underserved population. In considering applications for loan guarantees under this section, the Secretary shall give special consideration to applications for projects for health maintenance organizations which will serve medically underserved populations.

[(e)(1) Except as provided in paragraph (2), the following limitations apply with respect to grants, loan guarantees, and contracts made under subsection (a) of this section:

[(A) If a planning project has been assisted with grant, loan guarantee, or contract under subsection (a), the Secretary may not make any other planning grant or loan guarantee or enter into any other planning contract for such project under this section.

[(B) Any project for which a grant or loan guarantee is made or contract entered into must be completed within twelve months from the date the grant or loan guarantee is made or contract entered into.

[(2) The Secretary may not make more than one additional grant or loan guarantee or enter into not more than one additional contract for a planning project for which a grant or loan guarantee has previously been made or a contract previously entered into, and he may permit additional time (up to twelve months) for completion of the project if he determines that the additional grant,

loan guarantee, or contract (as the case may be), or additional time, or both, is needed to adequately complete the project.

[(f)(1) The amount to be paid by the United States under a grant made, or contract entered into, under subsection (a) for a planning project, and (except as provided in paragraph (3) of this subsection) the amount of principal of a loan for a planning project which may be guaranteed under such subsection, shall be determined by the Secretary, except that (A) the amount to be paid by the United States under any single grant or contract, and the amount of principal of any single loan guaranteed under such subsection, may not exceed $200,000, and (B) the aggregate of the amounts to be paid for any project by the United States under grants or contracts, or both, under such subsection, and the aggregate amount of principal of loans guaranteed under such subsection for any project, may not exceed the greater of (i) 90 per centum of the cost of such project (as determined under regulations of the Secretary), or (ii) in the case of a project for a health maintenance organization which will serve a medically underserved population, such greater percentage (up to 100 per centum) of such cost as the Secretary may prescribe if he determines that the ceiling on the grants, contracts, and loan guarantees (or any combination thereof) for such project should be determined by such greater percentage.

[(2) Except as provided in paragraph (3), the amount to be paid by the United States under a grant made, or contract entered into, under subsection (b) for an initial development project, and the amount of principal of a loan for an initial development project which may be guaranteed under such subsection, shall be determined by the Secretary; except that the amounts to be paid by the United States for any initial development project under grants or contracts, or both, under such subsection, and the aggregate amount of principal of loans guaranteed under such subsection for any project, may not exceed the lesser of—

[(A) $1,000,000 through September 30, 1979, and $2,000,000 thereafter, or

[(B) an amount equal to the greater of (i) 90 per centum of the cost of such project (as determined under regulations of the Secretary), or (ii) in the case of a project for a health maintenance organization which will serve a medically underserved population, such greater percentage (up to 100 per centum) of such cost as the Secretary may prescribe if he determines that the ceiling on the grants, contracts, and loan guarantees (or any combination thereof) for such project should be determined by such greater percentage.

[(3) The cumulative total of grants made to, contracts entered into with, and principal of loans guaranteed for, a health maintenance organization under subsection (b) of this section may not exceed $1,000,000 through September 30, 1979, or $2,000,000 thereafter. The cumulative total of the principal of the loans outstanding at any time with respect to which guarantees have been issued under this section may not exceed such limitations as may be specified in appropriation Acts.

[(g) Payments under grants under this section may be made in advance or by way of reimbursement and at such intervals and on such conditions as the Secretary finds necessary.

[(h) Contracts may be entered into under this section without regard to sections 3648 and 3709 of the Revised Statutes (31 U.S.C. 529; 41 U.S.C. 5).

[(i) Payments under grants and contracts under this section shall be made from appropriations under section 1309(a).

[(j) Loan guarantees under subsection (a)(2) for planning projects and loan guarantees under subsection (b)(1)(B) for initial development projects may be made through the fiscal year ending September 30, 1984] [Repealed.]

LOANS AND LOAN GUARANTEES FOR INITIAL COSTS OF OPERATION

SEC. 1305. (a) The Secretary may—

(1) make loans to public or private health maintenance organizations to assist them in meeting the amount by which their costs of operation during a period not to exceed the first sixty months of their operation exceed their revenues in that period;

(2) make loans to public or private health maintenance organizations to assist them in meeting the amount by which their costs of operation, which the Secretary determines are attributable to significant expansion in their membership or area served and which are incurrred during a period not to exceed the first sixty months of their operation after such expansion, exceed their revenues in that period which the Secretary determines are attributable to such expansion; and

(3) guarantee to non-Federal lenders payment of the principal of and the interest on loans made to private health maintenance organizations for the amounts referred to in paragraphs (1) and (2), *and unless the Secretary has made a grant or loan to, entered into a contract with, or guaranteed a loan for, the organization in fiscal year 1981, 1982, 1983, 1984 or 1985 under this section or section 1304(b) (as in effect before October 1, 1985).*

(b)(1) Except as provided in paragraph (2) the aggregate amount of principal of loans made or guaranteed, or both, under subsection (a) for a health maintenance organization may not exceed $7,000,000. In any twelve-month period the amount disbursed to a health maintenance organization under this section (either directly by the Secretary, by an escrow agent under the terms of an escrow agreement, or by a lender under a guaranteed loan) may not exceed $3,000,000.

(2) The cumulative total of the principal of the loans outstanding at any time which have been directly made or with respect to which guarantes have been issued under subsection (a) may not exceed such limitations as may be specified in appropriation Acts.

(c) Loans under this section shall be made from the fund established under section 1308(e).

(d) No loan may be made or guaranteed under this section after September 30, 1986.

(e) Of the sums used for loans under this section in any fiscal year from the loan fund established under section 1308(e), not less than 20 per centum shall be used for loans for projects (1) for the initial operation of health maintenance organizations which the Secretary determines have not less than 66 per centum of their

membership drawn from residents of nonmetropolitan areas, and (2) the applications for which meet the requirements of this title for approval.

(f) In considering applications for loan guarantees under this section, the Secretary shall give special consideration to applications for health maintenance organizations which will serve medically underserved populations.

LOANS AND LOAN GUARANTEES FOR ACQUISITION AND CONSTRUCTION OF AMBULATORY HEALTH CARE FACILITIES

[SEC. 1305A. (a) the Secretary may—

[(1) make loans, from the fund established under section 1308(e), to public and private health maintenance organizations for projects for the acquisition or construction of ambulatory health care facilities and for the acquisition of equipment or facilities acquired or constructed under a loan made under this paragraph; and

[(2) guarantee to non-Federal lenders for their loans to profit private health maintenance organizations for projects described in paragraph (1) the payment principal and interest on such loans.

[(b) No loan may be made to a health maintenance organization and no loan to a health maintenance organization may be guaranteed under subsection (a) unless the application of the health maintenance organization for such loan or loan guarantee contains assurance satisfactory to the Secretary that—

[(1) at the time the application is made the health maintenance organization is fiscally sound;

[(2) if the application is for a loan, the health maintenance organization is unable to secure a loan, at the rate of interest prevailing in the area in which the organization is located, from non-Federal lenders for the project with respect to which the application is submitted, or, if the application is for a loan guarantee, the health maintenance organization would be unable to secure a loan from such lenders for such project without the loan guarantee; and

[(3) during the period of the loan or loan guarantee, the health maintenance organization will remain fiscally sound.

[(c)(1) Except as provided in paragraph (2), the aggregate amount of principle of loans made or guaranteed, or both, under subsection (a) for an ambulatory health care facility may not exceed $2,500,000.

[(2) The cumulative total of the principal of the loans outstanding at any time which have been directly made or with respect to which guarantees have been issued under subsection (a) may not exceed such limitations as may be specified in appropriation Acts.

[(3) The authority of the Secretary to make loans under subsection (a) shall be effective for any fiscal year only to such extent or in such amounts as are provided in advance in appropriation Acts.

[(d) For purposes of this section—

[(1) the term "ambulatory health care facility" means a health care facility for the provision of diagnostic, treatment, and prevention services to ambulatory patients; and

[(2) the term "construction" means the (A) construction of new facilities, (B) alterations, expansion, remodeling, replacement, and renovation of existing facilities, (C) cost of offsite improvements in connection with an activity described in clause (A) or (B), and (D) cost of the acquisition of land in connection with an activity described in clause (A), (B), (C).] [Repealed.]

APPLICATION REQUIREMENTS

SEC. 1306. (a) No [grant, contract, loan.] *loan* or loan guarantee may be made under this title unless an application therefor has been submitted to and approved by the Secretary.

(b) The Secretary may not approve an application for a [grant, contract, loan,] *loan* or loan guarantee under this title unless—

(1) [in the case of an application for assistance under section 1303 or 1304, such application meets the application requirements of such section and in the case of an application for a loan or loan guarantee,] such application meets the requirements of section 1308;

(2) in the case of an application for assistance under section [1304] 1305, [or 1305A,] he detemines that the applicant making the application would not be able to complete the project or undertaking for which the application is submitted without the assistance applied for;

(3) the application contains satisfactory specification of the existing or anticipated (A) population group or groups to be served by the proposed or existing health maintenance organization described in the application, (B) membership of such organization, (C) methods, terms, and periods of the enrollment of members of such organization, (D) estimated costs per member of the health and educational services to be provided by such organization and the nature of such costs, (E) sources of professional services for such organization, and organizational arrangements of such organization for providing health and educational services, (F) organizational arrangements of such organization for an ongoing quality assurance program in conformity with the requirements of section 1301(c), (G) sources of prepayment and other forms of payment for the services to be provided by such organization, (H) facilities, and additional capital investments and sources of financing therefor, available to such organization to provide the level and scope of services proposed, (I) administrative, managerial, and financial arrangements and capabilities of such organization, (J) role for members in the planning and policymaking for such organization, (K) grievance procedures for members of such organization, and (L) evaluations of the support for and acceptance of such organization by the population to be served, the sources of operating support, and the professional groups to be involved or affected thereby;

(4) contains or is supported by assurances satisfactory to the Secretary that the applicant making the application will, in accordance with such criteria as the Secretary shall by regulation prescribe, enroll, and maintain an enrollment of the maximum number of members that its available and potential re-

sources (as determined under regulations of the Secretary) will enable it to effectively serve;

[(5) each health systems agency designated for a health service area which covers (in whole or in part) the area to be served by the health maintenance organization for which such application is submitted;]

[(6)] *(5)* in the case of an application made for a project which previously received a [grant, contract, loan] *loan* or loan guarantee under this title, such application contains or is supported by assurances satisfactory to the Secretary that the applicant making the application has the financial capability to adequately carry out the purposes of such project and has developed and operated such project in accordance with the requirements of this title and with the plans contained in previous applications for such assistance;

[(7)] *(6)* the application contains such assurances as the Secretary may require respecting the intent and the ability of the applicant to meet the requirements of paragraphs (1) and (2) of section 1301(b) respecting the fixing of basic health services payments and supplemental health services payments under a community rating system; and

[(8)] *(7)* the application is submitted in such form and manner, and contains such additional information, as the Secretary shall prescribe in regulations.

An organization making multiple applications for more than one [grant, contract, loan,] *loan* or loan guarantee under this title, simultaneously or over the course of time, shall not be required to submit duplicate or redundant information but shall be required to update the specifications (required by paragraph (3)) respecting the existing or proposed health maintenance organization in such manner and with such frequency as the Secretary may by regulation prescribe. In determining, for purposes of paragraph (2), whether an applicant would be able to complete a project or undertaking without the assistance applied for, the Secretary shall not consider any asset of the applicant the obligation of which for such undertaking or project would jeopardize the fiscal soundness of the applicant.

(c) The Secretary shall by regulation establish standards and procedures for health systems agencies to follow in reviewing and commenting on applications for [grants, contracts, loans,] *loans* and loan guarantees under this title.

ADMINISTRATION OF ASSISTANCE PROGRAMS

SEC. 1307. (a)(1) Each recipient of a [grant, contract, or,] *loan* or loan guarantee under this title shall keep such records as the Secretary shall prescribe, including records which fully disclose the amount and disposition by such recipient of the proceeds of the [grant, contract, or] *loan* (directly made or guaranteed), the total cost of the undertaking in connection with which [such assistance] the loan was given or used, the amount of that portion of the cost of the undertaking supplied by other sources, and such other records as will facilitate an effective audit.

(2) The Secretary, or any of his duly authorized representatives, shall have access for the purpose of audit and examination to any books, documents, papers, and records of the recipients of a [grant, contract, loan,] *loan* or loan guarantee under this title which relate to such assistance.

(b) Upon expiration of the period for which a [grant, contract, loan,] *loan* or loan guarantee was provided an entity under this title, such entity shall make a full and complete report to the Secretary in such manner as he may by regulation prescribe. Each such report shall contain, among such other matters as the Secretary may by regulation require, descriptions of plans, developments, and operations relating to the matters referred to in section 1306(b)(3).

[(c) If in any fiscal year the funds appropriated under section 1309 are insufficient to fund all applications approved under this title for the fiscal year, the Secretary shall after applying the applicable priorities under sections 1303 and 1304, give priority to the funding of applications for projects which the Secretary determines are the most likely to be economically viable.]

(d) An entity which provides health services to a defined population on a prepaid basis and which has members who are entitled to insurance benefits under title XVIII of the Social Security Act or to medical assistance under a State plan approved under title XIX of such Act may be considered as a health maintenance organization for purposes of receiving assistance under this title if—

(1) with respect to its members who are entitled to such insurance benefits or to such medical assistance it (A) provides health services in accordance with section 1301(b), except that (i) it does not furnish to those members the health services (within the basic health services) for which it may not be compensated under such title XVIII or such State plan, and (ii) it does not fix the basic or supplemental health services payment for such m embers under a community rating system, and (B) is organized and operated in the manner perscribed by section 1301(c), except that it does not assume full financial risk on a prospective basis for the provision to such members of basic or supplemental health services with respect to which it is not required under such title XVIII or such State plan to assume such financial risk; and

(2) with respect to its other members it provides health services in accordance with section 1301(b) and is organized and operated in the manner prescribed by section 1301(c).

An entity which provides health services to a defined population on a prepaid basis and which has members who are enrolled under the health benefits program authorized by chapter 89 of title 5, United States Code, may be considered as a health maintenance organization for purposes of receiving assistance under this title if with respect to its other members it provides health services in accordance with section 1301(b) and is organized and operated in the manner prescribed by section 1301(c).

GENERAL PROVISIONS RELATING TO LOAN GUARANTEES AND LOANS

SEC. 1308(a)(1) The Secretary may not approve an application for a loan guarantee under this title unless he determines that (A) the terms, conditions, security (if any), and schedule and amount of repayments with respect to the loan are sufficient to protect the financial interests of the United States and are otherwise reasonable including a determination that the rate of interest does not exceed such per centum per annum on the principal obligation outstanding as the Secretary determines to be reasonable, taking into account the range of interest rates prevailing in the private market for loans with similar maturities, terms, conditions, and security and the risks assumed by the United States and (B) the loan would not be available on reasonable terms and conditions without the guarantee under this title.

(2)(A) The United States shall be entitled to recover from the applicant for a loan guarantee under this title the amount of any payment made pursuant to such guarantee, unless the Secretary for good cause waives such right of recovery; and, upon making any such payment, the United States shall be subrogated to all of the rights of the recipient of the payments with respect to which the guarantee was made.

(B) To the extent permitted by subparagraph (C), any terms and conditions applicable to a loan guarantee under this title (including terms and conditions imposed under subparagraph (D)) may be modified by the Secretary to the extent he determines it to be consistent with the financial interest of the United States.

(C) Any loan guarantee made by the Secretary under this title shall be incontestable (i) in the hands of an applicant on whose behalf such guarantee is made unless the applicant engaged in fraud or misrepresentation in securing such guarantee, and (ii) as to any person (or his successor in interest) who makes or contracts to make a loan to such applicant in reliance thereon unless such person (or his successor in interest) engaged in fraud or misrepresentation in making or contracting to make such loan.

(D) guarantees of loans under this title shall be subject to such further terms and conditions as the Secretary determines to be necessary to assure that the purposes of this title will be achieved.

(b)(1) The Secretary may not approve an application for a loan under this title unless—

(A) the Secretary is reasonably satisfied that the applicant therefor will be able to make payments of principal and interest thereon when due, and

(B) the applicant provides the Secretary with reasonble assurances that there will be available to it such additional funds as may be necessary to complete the project or undertaking with respect to which such loan is requested.

(2) Any loan made under this title shall (A) have such security, (B) have such maturity date, (C) be repayable in such installments, (D) on the date the loan is made, bear interest at a rate comparable to the rate of interest prevailing on such date with respect to marketable obligations of the United States of comparable maturities, adjusted to provide for appropriate administrative charges, and (E) be subject to such other terms and conditions (including provisions

for recovery in case of default), as the Secretary determines to be necessary to carry out the purposes of this title while adequately protecting the financial interests of the United States. On the date disbursements are made under a loan after the initial disbursement under the loan, the Secretary may change the rate of interest on the amount of the loan disbursed on that date to a rate which is comparable to the rate of interest prevailing on the date the subsequent disbursement is made with respect to marketable obligations of the United States of comparable maturities, adjusted to provide for appropriate administrative charges.

(3) The Secretary may, for good cause but with due regard to the financial interests of the United States, waive any right of recovery which he has by reason of the failure of a borrower to make payments of principal of and interest on a loan made under this title except that if such loan is sold and guaranteed, any such waiver shall have no effect upon the Secretary's guarantee of timely payment of principal and interest.

(c)(1) The Secretary may from time to time, but with due regard to the financial interests of the United States, sell loans made by him under this title.

(2) The Secretary may agree, prior to his sale of any such loan, to guarantee to the purchaser (and any successor in interest of the purchaser) compliance by the borrower with the terms and conditions of such loan. Any such agreement shall contain such terms and conditions as the Secretary considers necessary to protect the financial interests of the United States or as otherwise appropriate. Any such agreement may (A) provide that the Secretary shall act as agent of any such purchaser for the purpose of collecting from the borrower to which such loan was made and paying over to such purchaser, any payments of principal and interest payable by such organization under such loan; and (B) provide for the repurchase by the Secretary of any such loan on such terms and conditions as may be specified in the agreement. The full faith and credit of the United States is pledged to the payment of all amounts which may be required to be paid under any guarantee under this paragraph.

(3) After any loan under this title to a public health maintenance organization has been sold and guaranteed under this subsection interest paid on such loan which is received by the purchaser thereof (or his successor in interest) shall be included in the gross income of the purchaser of the loan (Or his successor in interest) for the purpose of chapter 1 of the Internal Revenue Code of 1954.

(4) Amounts received by the Secretary as proceeds from the sale of loans under this subsection shall be deposited in the loan fund established under subsection (e).

(5) Any reference in this title (other than in this subsection and in subsection (d)) to a loan guarantee under this title does not include a loan guarantee made under this subsection.

(d)(1) There is established in the Treasury a loan guarantee fund (hereinafter in this subsection referred to as the "fund") which shall be available to the Secretary without fiscal year limitation, in such amounts as may be specified from time to time in appropriation Acts, to enable him to discharge his responsibilities under loan guarantees issued by him under this title and to take the action authorized by subsection (f). There are authorized to be appropri-

ated from time to time such amounts as may be necessary to provide the sums required for the fund. To the extent authorized in appropriation Acts, there shall also be deposited in the fund amounts received by the Secretary in connection with loan guarantees under this title and other property or assets derived by him from his operations respecting such loan guarantees, including any money derived from the sale of assets.

(2) If at any time the sums in the funds are insufficient to enable the Secretary to discharge his responsibilities under guarantees issued by him *before October 1, 1985,* under this title and to take the action authorized by subsection (f), he is authorized to issue to the Secretary of the Treasury notes or other obligations in such forms and denominations, bearing such maturities, and subject to such terms and conditions, as may be prescribed by the Secretary with the approval of the Secretary of Treasury. Such notes or other obligations shall bear interest at a rate determined by the Secretary of the Treasury, taking into consideration the current average market yield on outstanding marketable obligations of the United States of comparable maturities during the month preceding the issuance of the notes or other obligations. The Secretary of the Treasury shall purchase any notes and other obligations issued under this paragraph and for that purpose he may use as a public debt transaction the proceeds from the sale of any securities issued under the Second Liberty Bond Act, and the purposes for which the securities may be issued under that Act are extended to include any purchase of such notes and obligations. The Secretary of the Treasury may at any time sell any of the notes or other obligations acquired by him under this paragraph. All redemptions, purchases, and sales by the Secretary of the Treasury of such notes or other obligations shall be treated as public debt transactions of the United States. Sums borrowed under this paragraph shall be deposited in the fund and redemption of such notes and obligations shall be made by the Secretary from the fund.

(e) There is established in the Treasury a loan fund (hereinafter in this subsection referred to as the "fund") which shall be available to the Secretary without fiscal year limitation, in such amounts as may be specified from time to time in appropriation Acts, to enable him to make loans under this title and to take the action authorized by subsection (f). There shall also be deposited in the fund amounts received by the Secretary as interest payments and repayment of principal on loans made under this title and other property or assets derived by him from his operations respecting such loans, from the sale of loans under subsection (c) of this section, or from the sale of assets.

(f) The Secretary may take such action as he deems appropriate to protect the interest of the United States in the event of a default on a loan made or guaranteed under this title, including taking possession of, holding, and using real property pledged as security for such a loan or loan guarantee.

AUTHORIZATIONS OF APPROPRIATIONS

SEC. 1309. (a) [(1) For grants and contracts under sections 1303 and 1304 there is authorized to be appropriated $20,000,000 for the

fiscal years 1982, 1983, and 1984. No funds appropriated under this paragraph may be expended or obligated for a grant or contract unless the entity received a grant or contract under section 303 or 304 during or before the fiscal year 1981.] [(2)] For grants under section 1317 there is authorized to be appropriated $1,000,000 for each of the fiscal years 1982, 1983, and 1984.

(b) [To maintain in the loan fund established under section 1308(e) for the purpose of making new loans a balance of at least $5,000,000 at the end of each fiscal year and to meet the obligations of the loan fund resulting from defaults on loans from the fund and to meet the other obligations of the fund, there is authorized to be appropriated to the loan fund for fiscal years 1982, 1983, and 1984, such sums as may be necessary to assure such balance and meet such obligations.] *To meet the obligations of the loan fund established under section 1308(e) resulting from defaults on loans made from the fund and to meet the other obligations of the fund, there is authorized to be appropriated to the loan fund for fiscal years 1987, 1988, and 1989, such sums as may be necessary.*

EMPLOYEES HEALTH BENEFITS PLANS

SEC. 1310. (a)(1) In accordance with regulations which the Secretary shall prescribe—

(A) each employer—

(i) which is now or hereafter required during any calendar quarter to pay its employees the minimum wage prescribed by section 6 of the Fair Labor Standards Act of 1938 (or would be required to pay its employees such wage but for section 13(a) of such Act), and

(ii) which during such calendar quarter employed an average number of employees of not less than 25,

shall include in any health benefits plan, and

(B) any State and each political subdivision thereof which during any calendar quarter employed an average number of employees of not less than 25, as a condition of payment to the State of funds under section 314(c), 317, 318, 1002, 1525, or 1613, shall include in any health benefits plan.

offered to such employees in the calendar year beginning after such calendar quarter the option of membership in qualified health maintenance organizations which are engaged in the provision of basic health services in health maintenance organization service areas in which at least 25 of such employees reside.

(2) If any of the employees of an employer or State or political subdivision thereof described in paragraph (1) are represented by a collective bargaining representative or other employee representative designated or selected under any law, offer of membership in a qualified health maintenance organization required by paragraph (1) to be made in a health benefits plan offered to such employees (A) shall first be made to such collective bargaining representative or other employee representative, and (B) if such offer is accepted by such representative, shall then be made to each such employee.

(b) If there is more than one qualified health maintenance organization which is engaged in the provision of basic and supplemen-

tal health services in the area in which the employees of an employer subject to subsection (a) reside and if—

(1) one or more of such organizations provides more than one-half of its basic health services which are provided by physicians through physicians or other health professionals who are members of the staff of the organization or a medical group (or groups), and

(2) one or more of such organizations provides its basic health services which are provided by physicians through (A) an individual practice association (or associations), (B) individual physicians and other health professionals under contract with the organization, or (C) a combination of such association (or associations), medical group (or groups), staff, and individual physicians and other health professionals under contract with the organization,

then of the qualified health maintenance organizations included in a health benefits plan of such employer pursuant to subsection (a) at least one shall be an organization which provides basic health services as described in clause (1) and at least one shall be an organization which provides basic health services as described in clause (2).

(c) No employer shall be required to pay more for health benefits as a result of the application of this section than would otherwise be required by any prevailing collective bargaining agreement or other legally enforceable contract for the provision of health benefits between the employer and its employees. Each employer which provides payroll deductions as a means of paying employees' contributions for health benefits or which provides a health benefits plan to which an employee contribution is not required and which is required by subsection (a) to offer his employees the option of membership in a qualified health maintenance organization shall, with the consent of an employee who exercises such option, arrange for the employee's contribution for such membership to be paid through payroll deductions.

(d) For purposes of this section, the term "qualified health maintenance organization" means (1) a health maintenance organization which has provided assurances satisfactory to the Secretary that it provides basic and supplemental health services to its members in the manner prescribed by section 1301(b) and that it is organized and operated in the manner prescribed by section 1301(c), and (2) an entity which proposes to become a health maintenance organization and which the Secretary determines will when it becomes operational provide basic and supplemental health services to its members in the manner prescribed by section 1301(b) and will be organized and operated in the manner prescribed by section 1301(c). [Every two years (or such longer period as the Secretary may by regulation prescribe) after the date a health maintenance organization becomes a qualified health maintenance organization under this subsection, the health maintenance organization must demonstrate to the Secretary that it is qualified within the meaning of this subsection.]

(e)(1) Any employer who knowingly does not comply with one or more of the requirements of subsection (a), (b) or (c) shall be subject to civil penalty of not more than $10,000. If such noncompliance

continues, a civil penalty may be assessed and collected under this subsection for each thirty-day period such noncompliance continues. Such penalty may be assessed by the Secretary and collected in a civil action brought by the United States in a United States district court.

(2) In any proceeding by the Secretary to assess a civil penalty under this subsection, no penalty shall be assessed until the employer charged shall have been given notice and an opportunity to present its views on such charge. In determining the amount of the penalty, or the amount agreed upon in compromise, the Secretary shall consider the gravity of the noncompliance and the demonstrated good faith of the employer charged in attempting to achieve rapid compliance after notification by the Secretary of a noncompliance.

(3) In any civil action brought to review the assessment of a civil penalty assessed under this subsection, the court shall, at the request of any party to such action, hold a trial de novo on the assessment of such civil penalty and in any civil action to collect such a civil penalty, the court shall, at the request of any party to such action, hold a trial de novo on the assessment of such civil penalty unless in a prior civil action to review the assessment of such penalty the court held a trial de novo on such assessment.

(f) for purposes of this section, the term "employer" does not include (1) the Government of the United States, the government of the District of Columbia or any territory or possession of the United States, a State or any political subdivision thereof, or any agency or instrumentality (including the United States Postal Service and Postal Rate Commission) of any of the foregoing, except that such term includes nonappropriated fund instrumentalities of the Government of the United States; or (2) a church, convention or association of churches, or any organization operated, supervised or controlled by a church, convention or association of churches which organization (A) is an organization described in section 501(c)(3) of the Internal Revenue Code of 1954, and (B) does not discriminate (i) in the employment, compensation, promotion, or termination of employment of any personnel, or (ii) in the extension of staff or other privileges to any physician or other health personnel, because such persons seek to obtain or obtained health care, or participate in providing health care, through a health maintenance organization.

(g) If the Secretary, after reasonable notice and opportunity for hearing to a State, finds that it or any of its political subdivisions has failed to comply with one or more of the requirements of subsection (a), the Secretary shall terminate payments to such State under sections 314(d), 317, 318, 1002, 1525, and 1613 and notify the Governor of such State further payments under such sections will not be made to the State until the Secretary is satisfied that there will no longer be any such failure to comply.

RESTRICTIVE STATE LAWS AND PRACTICES

SEC. 1311 (a) In the case of any entity—

(1) which cannot do business as a health maintenance organization in a State in which it proposes to furnish basic and

supplemental health services because that State by law, regulation, or otherwise—

(A) requires as a condition to doing business in that State at a medical society approve the furnishing of services by the entity,

(B) requires that physicians constitute all or a percentage of its governing body,

(C) requires that all physicians or a percentage of physicians in the locale participate or be permitted to participate in the provision of service for the entity, or

(D) requires that the entity requirements for insurers of health care services doing business in that State respecting initial capitalization and establishment of financial reserves against insolvency, and

(2) for which a grant, contract, loan, or loan guarantee was made under this title or which is a qualified health maintenance organization for purposes of section 1310 (relating to employees' health benefits plans),

such requirements shall not apply to that entity so as to prevent it from operating as a health maintenance organization in accordance with section 1301.

(b) No State may establish or enforce any law which prevents a health maintenance organization for which a grant, contract, loan, or loan guarantee was made under this title or which is a qualified health maintenance organization for purposes of section 1310 (relating to employees' health benefits plans), from soliciting members through advertising its services, charges, or other nonprofessional aspects of its operation. This subsection does not authorize any advertising which identifies, refers to, or makes any qualitative judgment concerning, any health professional who provides services for a health maintenance organization.

(c) The Secretary shall, within 6 months after the date of the enactment of this subsection, develop a digest of State laws, regulations, and practices pertaining to development, establishment, and operation of health maintenance organizations which shall be updated at least [quarterly] *annually* and relevant sections of which shall be provided to the Governor of each State annually. Such digest shall indicate which State laws, regulations, and practices appear to be inconsistent with the operation of this section. The Secretary shall also insure that appropriate legal consultative assistance is available to the States for the purpose of complying with the provisions of this section.

CONTINUED REGULATION OF HEALTH MAINTENANCE ORGANIZATIONS

SEC. 1312. (a) If the Secretary determines that an entity which received a grant, contract, loan, or loan gurantee under the title as a health maintenance organization or which was included in a health benefits plan offered to employees pursuant to section 1310—

(1) fails to provide basic and supplemental services to its members,

(2) fails to provide such services in the manner prescribed by section 1301(b), or

(3) is not organized or operated in the manner prescribed by section 1301(c),

the Secretary may take the action authorized by subsection (b).

(b)(1) If the Secretary makes, with respect to any entity which provided assurances to the Secretary under section 1310(d)(1), a determination described in subsection (a), the Secretary shall notify the entity in writing of the determination. Such notice shall specify the manner in which the entity has not complied with such assurances and direct that the entity initiate (within 30 days of the date the notice is issued by the Secretary or within such longer period as the Secretary determines is reasonable) such action as may be necessary to bring (within such period as the Secretary shall prescribe) the entity into compliance with the assurances. If the entity fails to initiate corrective action within the period prescribed by the notice or fails to comply with the assurances within such period as the Secretary prescribes, then after the Secretary provides the entity a reasonable opportunity for reconsideration of his determination, including, at the entity's election, a fair hearing (A) the entity shall not be a qualified health maintenance organization for purposes of section 1310 until such date as the Secretary determines that it is in compliance with the assurances, and (B) each employer which has offered membership in the entity in compliance with section 1310, each lawfully recognized collective bargaining representative or other employer representative which represents the employees of each such employer, and the members of such entity shall be notified by the entity that the entity is not a qualified health maintenance organization for purposes of such section. The notice required by clause (B) of the preceding sentence shall contain, in readily understandable language, the reasons for the determination that the entity is not a qualified health maintenance organization. The Secretary shall publish in the Federal Register each determination referred to in this paragraph.

(2) If the Secretary makes, with respect to an entity which has received a grant, contract, loan, or loan guarantee under this title, a determination described in subsection (a), the Secretary may, in addition to any other remedies available to him, bring a civil action in the United States district court for the district in which such entity is located to enforce its compliance with the assurances it furnished respecting the provision of basic and supplemental health services or its organization or operation, as the case may be, which assurances were made in connection with its application under this title for the grant, contract, loan, or loan guarantee.

LIMITATION ON SOURCE OF FUNDING YOUR HEALTH MAINTENANCE ORGANIZATIONS

SEC. 1313. No funds appropriated under any provision of this Act (except as provided in sections 329, 330, and 340) other than this title may be used—

(1) for grants or contracts for surveys or other activities to determine the feasibility of developing or expanding health maintenance organizations or other entities which provide, directly or indirectly, health services to a defined population on a prepaid basis;

(2) for grants or contracts, or for payments under loan guarantees, for planing projects for the establishment or expansion of such organizations or entities;

(3) for grants or contracts, or for payments under loan guarantees, for projects for the initial development or expansion of such organizations or entities; or

(4) for loans, or for payments under loan guarantees, to assist in meeting the costs of the initial operation after establishment or expansion of such organization or entities or in meeting the costs of such organizations in acquiring or constructing ambulatory health care facilities.

Sec. 1314. Repealed.

ANNUAL REPORT

SEC. 1315. (a) The Secretary shall periodically review the programs of assistance authorized by this title and make an annual report to the Congress of a summary of the activities under each program. The Secretary shall include in such summary—

(1) a summary of each grant, contract, loan, or loan guarantee made under this title in the period covered by the report and a list of the health maintenance organizations which during such period became qualified health maintenance organizations for purposes of section 1320;

(2) the statistics and other information reported in such period to the secretary in accordance with section 1301(c)(11);

(3) findings with respect to the ability of the health maintenance organizations assisted under this title—

(A) to operate on a fiscally sound basis without continued Federal financial assistance,

(B) to meet the requirements of section 130(c) respecting their organization and operation,

(C) to provide basic and supplemental health services in the manner prescribed by section 1301(b),

(D) to include indigent and high-risk individuals in their membership, and

(E) to provide services to medically underserved populations; and

(4) findings with respect to—

(A) the operation of distinct categories of health maintenance organizations in comparsion with each other,

(B) health maintenance organizations as a group in comparison with alternative forms of health care delivery, and

(C) the impact that health maintenance organizations, individually, by category, and as a group, have on the health of the public.

(b) The Office of Management and Budget may review the Secretary's report under subsection (a) before its submission to the Congress but the Office may not revise the report or delay its submission, and it may submit to the Congress its comments (and those of other departments or agencies of the Government) respecting such report.

SEC. 1316. Repealed.

TRAINING AND TECHNICAL ASSISTANCE

SEC. 1317. (a)(1) The Secretary shall establish a National Health Maintenance Organization Intern Program (hereinafter in this subsection referred to as the "Program") for the purpose of providing training to individuals to become administrators and medical directors of health maintenance organizations or to assume other managerial positions with health maintenance organizations. Under the Program the Secretary may directly provide internships for such training and may make grants to or enter into contracts with health maintenance organizations and other entities to provide such internships.

(2) No internship may be provided by the Secretary and no grant may be made or contract entered into by the Secretary for the provision of internship unless an application therefor has been submitted to and approved by the Secretary. Such an application shall be in such form and contain such information, and be submitted to the Secretary in such manner, as the Secretary shall prescribe. Section 1306 does not apply to an application submitted under this section.

(3) Internships under the Program shall provide for such stipends and allowances (including travel and subsistence expenses and dependency allowances) for the recipients of the internships as the Secretary deems necessary. An internship provided an individual for training at a health maintenance organization or any other entity shall also provide for payments to be made to the organization or other entity for the cost of support services (including the cost of salaries, supplies, equipment, and related items) provided such individual by such organization or other entity. The amount of any such payments to any organization or other entity shall be determined by the Secretary and shall bear a direct relationship to the reasonable costs of the organization or other entity for establishing and maintaining its training programs.

(4) Payments under grants under the Program may be made in advance or by way of reimbursement, and at such intervals and on such conditions, as the Secretary finds necessary.

(b) The Secretary shall provide technical assistance [(1) to entities in connection with projects for which assistance is being provided under section 1303 or 1304,] [(2)] *(1)* to entities intending to become a qualified health maintenance organization within the meaning of section 1310(d), and [(3)] *(2)* to health maintenance organizations. The Secretary may provide such technical assistance through grants to public and nonprofit private entities and contracts with public and private entities.

(c) The authority of the Secretary to enter into contracts under subsections (a) and (b) shall be effective for any fiscal year only to such extent or in such amounts as are provided in advance by appropriation Acts.

FINANCIAL DISCLOSURE

SEC. 1318. (a) Each health maintenance organization shall, in accordance with regulations of the Secretary, report to the Secretary financial information which shall include the following:

(1) Such information as the Secretary may require demonstrating that the health maintenance organization has a fiscally sound operation.

(2) A copy of the report, if any, filed with the Health Care Financing Administration containing the information required to be reported under section 1124 of the Social Security Act by disclosing entities and the information required to be supplied under section 1902(a)(38) of such Act.

(3) A description of transactions, as specified by the Secretary, between the health maintenance organization and a party in interest. Such transactions shall include—

(A) any sale or exchange, or leasing of any property between the health maintenance organization and a party in interest;

(B) any furnishing for consideration of goods, services (including management services), or facilities between the health maintenance organization and a party in interest, but not including salaries paid to employees for services provided in the normal course of their employment and health services provided to members by hospitals and other providers and by staff, medical group (or groups), individual practice association (or associations), or any combination thereof; and

(C) any lending of money or other extension of credit between a health maintenance organization and a party in interest.

The Secretary may require that information reported respecting a health maintenance organization which controls, is controlled by, or is under common control with, another entity be in the form of a consolidated financial statement for the organization and such entity.

(b) For the purposes of this section the term "party in interest" means:

(1) any director, officer, partner, or employee responsible for management or administration of a health maintenance organization, any person who is directly or indirectly the beneficial owner of more than 5 per centum of the equity of the organization, any person who is the beneficial owner of a mortgage, deed of trust, note, or other interest secured by, and valuing more than 5 per centum of the health maintenance organization, and, in the case of a health maintenance organization organized as a nonprofit corporation, an incorporator or member of such corporation under applicable State corporation law;

(2) any entity in which a person described in paragraph (1)—

(A) is an officer or director;

(B) is a partner (if such entity is organized as a partnership);

(C) has directly or indirectly a beneficial interest of more than 5 per centum of the equity; or

(D) has a mortgage, deed of trust, note, or other interest valuing more than 5 per centum of the assets of such entity;

(3) any person directly or indirectly controlling, controlled by, or under common control with a health maintenance organization; and

(4) any spouse, child, or parent of an individual described in paragraph (1).

(c) Each health maintenance organization shall make the information reported pursuant to subsection (a) available to its enrollees upon reasonable request.

(d) The Secretary shall, as he deems necessary, conduct an evaluation of transactions reported to the Secretary under subsection (a)(3) for the purpose of determining their adverse impact, if any, on the fiscal soundness and reasonableness of charges to the health maintenance organization with respect to which they transpired. The Secretary shall evaluate the reported transactions of not less than five, or if there are more than twenty health maintenance organizations reporting such transactions, not less than one-fourth of the health maintenance organizations reporting any such transactions under subsection (a)(3).

[(e) The Secretary shall file an annual report with the Congress on the operation of this section. Such report shall include—

(1) an enumeration of standards and norms utilized to make the evaluations required under subsection (d);

(2) an assessment of the degree of conformity or nonconformity of each health maintenance organization evaluated by the Secretary under subsection (d) with such standards and norms;

(3) what action, if any, the Secretary considers necessary under section 1312 with respect to health maintenance organizations evaluated under subsection (d).] [Repealed.]

(f) Nothing in this section shall be construed to confer upon the Secretary any authority to approve or disapprove the rates charged by any health maintenance organization.

(g) Any health maintenance organization failing to file with the Secretary the annual financial statement required in subsection (a) shall be ineligible for any Federal assistance under this title until such time as such statement is received by the Secretary and shall not be a qualified health maintenance organization for purposes of section 1310.

(h) Whoever knowingly and willfully makes or causes to be made any false statement or representation of a material fact in any statement filed pursuant to this section shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

ADDITIONAL VIEWS OF MESSRS. NICKLES AND WALLOP

We oppose the reauthorization of the Health Maintenance Organization statute. While we heartily support the existence and proliferation of alternative health insurance plans like HMOs, we do not believe that the federal government needs to continue to provide preferential treatment to the HMO industry.

The HMO law which the Committee proposes to reauthorize requires any employer with over 25 employees to offer an HMO plan to its employees. This "dual choice mandate" kicks in when an HMO in a company's service area approaches an employer with their coverage plan. The employer is then required to offer that HMO or another HMO plan to its employees in addition to any other coverage that he has already provided. Once again Congress is trying to make decisions for business which should be left to the private sector.

Obviously, this preferential treatment to the HMO industry gives them a competitive advantage not shared by traditional insurers, or even other alternative plans like PPO's. The original law was passed in 1973 to encourage the creation of HMO health plans. At that time there were 72 HMO plans. As of 1985, there are 308 federally qualified HMOs. Obviously, the law has been quite successful. In just the last year alone, membership in HMO plans increased by 87%. This does not sound like an industry that needs federal assistance.

Year	Federally certified HMO's	Percent increase
1981	133	
1982	151	13
1983	184	21
1984	221	20
1985	308	39

It is also interesting to note that half of the existing HMOs are owned by for-profit companies, often in large national chains. In addition, major providers like Blue Cross/Blue Shield, Prudential, and Aetna have decided to join this lucrative and trendy industry by starting their own HMOs. Again, this does not sound like an industry that needs a federally created advantage.

Also authorized in this legislation is $400,000 for training and technical assistance to individuals and organizations who are interested in establishing and running an HMO. We do not believe this money is needed by an industry which has professional multi-million dollar companies of the caliber already cited running HMOs. Indeed, they could probably instruct Washington on how to create and successfully market HMOs.

For these reasons, we voted against the reauthorization of the HMO statute. It is always much easier to create rather than repeal programs. But, we believe this is an area where the federal government can say, "well done," and retreat, confident that market forces are there to continue the success of the HMO industry.

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